CHILD TREATMENT AND THE THERAPY OF PLAY

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INTRODUCTION

FEW people will quarrel with the contention that no community can rest on sound foundations unless the well-being of the child is the first charge upon the legislator.

To-day we do not regard health as limited to bodily well-being alone. The Good Society is not built on bricks and mortar, nor will equitable wages and the just distribution of opportunities in themselves establish happiness though they may do much to help towards that end. The enjoyment of happiness is made possible in a large measure where economic security and opportunity are made available to all who are capable of profiting from them. But there are irreducible mental requirements without which the capacity to enjoy is seriously curtailed. Enjoyment is a creative process only to those who are liberated from the thraldom to emotional conflicts which have their origin in the early and formative years of life.

Modern psychology, particularly in its medical aspects, can claim to have demonstrated that much unhappiness which clogs the growth of normal mental life in its individual and social aspects is the consequence of poor adaptation in the years of childhood. This poverty in adaptation arises maybe from certain inborn dispositions, but nevertheless the stresses of the child in relation to its early family environment incubate any tendencies which may exist at birth.

The human infant is from the first handicapped by its long dependence upon parental care and goodwill. It does not articulate in infancy its sense of frustration and longing, and for a considerable period before it has the gift of the language to express to itself and to others the causes of its discontents, it constructs in fantasy a world of notions having both a real and an imaginary representation in its play. To the child the parent is both good and bad at once, and the child's subsequent capacity for objectivity will depend to a large degree upon the way in which its testing of reality with the parents' assistance helps to make good working adjustments to the world of things and persons. The parents eat sour grapes and the children's teeth are set on edge. Thus the generations breed the seed of ill-will and unhappiness in their children. This is the very core of the human tragi-comedy, at least on the psychological level.

Unless we cope with this nuclear problem, skilfully dissecting out what is the seed of decay, we shall leave the child with a legacy of distorting influences which, combined with wider economic and social stresses, produces the major problems of civilization.

Modern Child Psychiatry holds out very reasonable hope that with the deeper understanding of the child's fantasy life so clearly disclosed in its play, we shall so influence medical, educational, and social techniques that a happier, because better adjusted, community becomes possible. The building of society is essentially a product of many agencies working together organically, and the psychologist cannot alone build the Brave New World.

Nevertheless the care and treatment of the individual child cannot be dispensed with, and the approach of the authors of this book in the handling of both child and parent is a most valuable contribution to this end. It is clear that they have watched their young patients with a scientific detachment, which has not destroyed that sympathy without which the helping of others might easily become a sterile endeavour. They handle their data with reserve and a commendable absence of dogmatism, which is so necessary in a subject which the authors themselves are developing during the difficult years of war. It is to be hoped that their work will inspire those who read this book to further the study of children, and thus aid in the growth of a technique which is as fascinating to the practitioner as it is fruitful to the young patient on his road to maturity.

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PREFACE

PLAY has always been a natural expression of childhood. Children have played all down the ages: they have played with things, they have played with each other; they have played at make-believe, at being grown-up; and in their play they have taken flight into the larger world of imagination. It is only recently that this spontaneous activity has been developed into a method of exploring the child's mind and that a 'therapy of play' has emerged as a form of treatment of psychological disorders.

The term 'play-therapy' has come to be used somewhat loosely, so that a variety of meanings has become attached to it. It has been erroneously thought that play in itself could cure a child of his nervous symptoms, and that to let the child play freely was sufficient to achieve recovery.

The authors of this book hope to clarify the term, to show in what ways play can be used as a therapeutic method, and to assign that method to its proper place—an important one but not the only one—among the many methods which are now being used in the psychological treatment of young children. They hope to convince the reader that play-therapy is a highly specialized branch of child-treatment, and not to be embarked upon by the untrained, however enthusiastic child lovers they may be.

The terms 'neurosis' and 'neurotic' are used throughout the book. The word neurosis is the most useful generic term under which one can include the many types of emotional disturbance: states of anxiety, behaviour anomalies, habit disorders, and obsessional conditions. This word, and still more so its adjective, have unfortunately come to have a derogatory connotation of recent years: they suggest irresponsibility, childishness, perhaps lack of character, and carry with them some measure of adverse criticism. No such meaning is attached to them in this book. The authors adhere to the original meaning.

Obsessional states have been given, perhaps, a disproportionate consideration, but the writers believe that as very little has been written on this condition in young children, especially in relation to the therapy of play, the subject deserved fuller treatment.

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CHAPTER I

THEORIES OF PLAY

'He intent, is all on his play-business bent . . .'

CHILDREN and young animals play spontaneously, without encouragement or example; it is generally taken for granted that the impulse to play is innate in man and the higher mammals. Few even serious-minded people give the subject a second thought, and there are many who look upon children's absorption in play as an inevitable nuisance. Those, however, who make childhood their study, educationists and child psychologists, have wondered for some time past about the function of play, its part in the development of the creature, and the biological why and wherefore of this puzzling activity. It is puzzling to the student of human nature because it seems to occur for no apparent reason except the creature's inclination, and does not appear, superficially, to have, like most other unlearned activities, a fairly obvious biological aim.

When we say 'play' we mean an activity distinct from both work and games, which is pursued for its own sake, and is free from compulsion inherent in the necessity of completing a task, as well as from the keen sense of rivalry which enters into most games. Such play we see, perhaps in its purest form, in a young kitten which hides, and bounces, and leaps on chairs and tables, its tail fluffed up and erect, its eyes round with excitement, or in a young child who runs about shouting and laughing, jumping and dancing, seeming to be completely dominated by an irrepressible desire for noise and movement.

In this type of play there is little difference between the behaviour of the human child and the young of other mammals; and the biological continuity in the development of the impulse becomes apparent. It is clearly an impulse which comes into being on a fairly high level of evolution: we have not met with evidence showing that creatures like earth-worms, frogs, or fishes indulge in genuine play, whereas most four-footed animals clearly do so early in life, for periods of varying length.

An unlearned activity which human beings share with animals usually goes by the name of instinct. As play appears to be unlearned, the question naturally arose whether the impulse to

play could be regarded as an instinct. Some authorities regarded it as such, among them Groos, who worked out a theory of play which is still found acceptable by certain students of the subject. Groos concluded from his observations of children and young animals that play was Nature's own method of teaching her creatures how to use their capacities. It was, in a sense, a school for the training of instincts. The crouching and leaping kitten was really learning how to catch a mouse. The wrestling puppies were practising ways and means by which to overpower their rivals in their pursuit of a female or of prey. The little girl nursing a doll was exercising in play the function of motherhood. This theory attracted many adherents by its charming plausibility. It reflected the practical genius of the German mind, and made a special appeal to the rationalist.

McDougall's Celtic imagination brought to bear upon the subject produced a brilliant criticism of Groos's theory. He, who was the first to put the vague theories of instinct into shape, began by denying that the impulse to play was an instinct in its own right. His definition of instinct has it clearly that it is a specific impulse to a specific activity, accompanied by a specific emotion. Thus, the instinct of combat is aroused by a situation of rivalry, frustration, or obstacle to some strong need or desire, issues in the activity of fighting, and is generally accompanied by anger. The instinct of escape is aroused by the perception of danger, issues in the activity of flight, and is accompanied by the emotion of fear. Play has no such definite pattern. It is not a response to any particular external situation; it may include a great number of activities; it has no goal, it is pursued for its own sake, and its emotion, if any, is one of enjoyment. Therefore, McDougall concludes, it is not an instinct *per se*.

THE PLAY OF ANIMALS

Can it then be a method for exercising the instincts? This question McDougall answers by analysing the play of young dogs.

> They race to and fro, they leap and turn, they roll one another over, they bite and bark, they seize one another by the throat, they lie down and roll over on their backs, and they adopt a great variety of attitudes. If an instinct were merely a motor mechanism, play would have to be regarded as the expression not of one instinct but of many, or of all.

If real, recognized instincts are at work, such as one of combat and one of escape, how are they so modified that no real

damage is done? Besides, mature animals also play, such as a grown dog with a puppy. In such cases the explanation of 'practice' and 'learning' can hardly be applied.

> The problem appears more clearly, continues McDougall, if we consider the special feature of dogs' play, which consists in one biting the other. The problem is: how are we to interpret the fact that, in such playful fighting, the biter never drives home his teeth, while the other often makes no effort to escape or defend himself, but rather lies on his back, presenting his undefended throat and belly to his fellow, in a way he will never do in real fight. Clearly, if the combative instinct is at work, it is working in a strangely modified fashion.
>
> Further, it is as clear as daylight that the combative emotion—anger—does not accompany these activities. Playful struggling may readily turn to real fighting; but as soon as one of the players displays anger, the play is at an end, giving place to real combat, or at least to preliminary threats.
>
> In addition to these considerations, the circumstances which evoke the impulse and the emotion of the combative instinct are lacking in play. Neither dog is pursuing an instinctive goal; and therefore there is no impulse at work the thwarting of which would provoke anger. The same is true of the playful actions which seem to be expressive of other instincts. The one dog flees and the other pursues, but the fleeing dog is not really striving to escape, and shows no sign of fear. And the pursuer is not really hunting him; does not attempt to seize him if he comes near him; does not yap as he would if he were pursuing game; and he experiences, we may feel sure, little or none of the emotional excitement proper to the hunt.

McDougall draws the conclusion that 'since neither the occasions, nor the symptoms, nor the movements of the playing animals are those characteristic of instinctive activities which the play simulates, the corresponding instincts are not really at work, or at play'. Play is an activity for its own sake, without a utilitarian significance, it is non-purposive and free, hence, perhaps, the peculiar delight which pertains to it.

Whence, however, comes the energy which sustains it? McDougall's answer is that a well-fed, well-rested animal has a surplus of neural energy which finds its way out through various motor mechanisms. In a caged beast this unused energy comes out in prowling round and round the cage; in a schoolboy, chained to his desk, in fidgeting; in a sailor, confined to his ship, in pacing the deck; in a young horse, released from his narrow stable, in frisking about and kicking up his heels.

There is no sign of emotion or of purposive effort in all this. The surplus energy must be expended somehow.

THE PLAY OF CHILDREN

The situation is more complex, however, where the play of human children is concerned. There, the plausible and simple explanation of surplus energy which needs to be expended, strikes us as incomplete. No doubt, it still applies: we observe this type of play in very young children, who play with their limbs, with the sounds they can produce, with any object that comes within their grasp, endlessly repeating and varying the movements and the sounds. But even this, the simplest type of play, soon becomes experimental and exploratory in the human child. As he kicks his legs in various directions, grasps and releases his own fingers, toes, and feet, produces vowels, consonants, and their combinations, he is exploring the limits of his power and trying out the extent of his capacities. He is, no doubt, learning, although unwittingly, how to exercise his various functions. The learning, however, is incidental to the infant's activities; it is a by-product of play, and this constitutes the point of divergence between Groos and ourselves, our view being the development of McDougall's.

This motor-sensory, exploratory, experimental play, characteristic of the first year of life, does not, of course, disappear completely as the child grows older. Older children delight in play which appears to be purely motor: in running wildly about, jumping, climbing, and twisting their limbs into all sorts of contortions, although in an older child this type of play may be expressive of some psychological need, such as to assert himself, to attract attention, to dominate.

IMITATIVE PLAY

Quite a different type of play makes its appearance sometimes as early as the second year of life; the kind of play which might be described as imitative. The child will try to reproduce the actions of those around him; he may pretend to 'read' a newspaper, like his father, or to sweep the floor like his mother; in other words, he would play at 'doing things'.

To what extent this type of play can be regarded as purely imitative is a moot question. Perhaps no type of play can be regarded as being purely of one or another kind, most of human activities being complex and of a mixed type. In any case, the

controversy about the existence of an 'impulse to imitate' for imitation's sake, is a long-standing one in psychology. It is argued that imitation is selective, that of a thousand-and-one things that we might imitate, we pick out a few which appeal to us for some, not always obvious, perhaps even unconscious, reasons. A toddler, who puckers his forehead and holds a paper in front of his face, may obtain for a few moments the vicarious satisfaction of feeling as important, as big and as powerful, as his father, enjoying the respect and attention shown to his father during his hour of relaxation by other members of the family. A little girl who grasps the handle of a carpet-sweeper and pushes it up and down the floor, may feel for a moment that her efforts are as useful to the household as her mother's; or she may be reacting to her mother's reproach for being 'a messy child', and demonstrating to the world that she can be tidy as well.

Thus, it might be correct to say that imitative play is never purely imitative, for it is doubtful that imitation is ever practised for its own sake. Yet all play is, in a sense, imitative, as it is clearly impossible for the child to avoid reproducing what he sees around him, for after all, his environment is his major stimulus to learning at this early age. But he selects what he reproduces, and his selection is governed by preferences which might indicate the predominance of certain instinctive trends as well as certain unconscious motives, as in the boy who moulds all his behaviour on that of a favoured older brother. For that reason imitative play might have some diagnostic value, although in a less degree than dramatic play, which appears at a later age.

We should, perhaps, emphasize that there is no such clear-cut distinction between play of various kinds as our attempt at classification might imply, and no definite stages at which one type of play disappears and is replaced by another. Some characteristics of the child's play are, no doubt, determined by the phases of mental and physical development in which he finds himself. Not until he emerges from the state of infantile self-absorption and acquires good control of his limbs, can he begin to play at reading a newspaper or sweeping the floor. And only after he has acquired command over a variety of means of expression by word and gesture, can he dramatize his experiences in imaginative play. Yet the rudiments of both imitative and dramatic play begin to appear at an age when the

child is still far from possessing the abilities required for their full realization. An infant of ten months might put his hands in front of his eyes, as his mother does, and laugh, as he uncovers his face, in the dramatic reproduction of a familiar, yet disturbing experience of her periodic disappearances. An eighteen months' old child might play, like Freud's little patient, a game characteristic of his age, which consists in throwing a toy out of his cot, then pulling it in at the end of a string, thus, perhaps, dramatizing his mother's frequent absences and returns. The motor-sensory type of play continues at least throughout childhood, and experimental-exploratory play throughout adolescence, if not through adulthood. Phases in play development would be defined more by the predominance of a certain type of play than by the exclusion of some other.

DRAMATIC PLAY

Dramatic play is the type which interests us especially because of its therapeutic possibilities.

The function of dramatic or imaginative play is very complex, for it may be an expression of a variety of needs. When we see a child play at being a coachman and whipping his 'horse' unmercifully, or at being a car driver and running people over in the street, we might be tempted to take a superficial view that he is merely 'imitating' what he had seen or heard. We might also jump to a hasty conclusion that he is a cruel or 'sadistic' child, who enjoys inflicting pain in imagination. Both these views may be partially true. Yet it may also be true that the child is seeking to satisfy a craving for power, which he has little chance of exercising in real life. He may be 'doing unto others' what he has had 'done unto himself', passing on to the imaginary horse or the imaginary person, the pain, the fear, the crushing sense of impotence, which others had inflicted upon him. He may, by working himself up into a state of angry excitement or of highly pleasurable sense of mastery, seek the experience, and learn the control of the emotions which he is obliged to repress in his everyday relationships. He may be even imagining himself as the chastised horse or the crushed pedestrian, thus allaying, through punishment, his guilt in connexion with his own 'naughtiness' or badness, and at the same time finding reassurance in the discovery that, after all, punishment does not annihilate the culprit—something that he had unconsciously feared. By providing objects for the

child's emotions, dramatic play becomes a safe vehicle of negative projection—the tendency common to both children and adults to ascribe their own, mostly antagonistic, feelings to persons in their environment—and thus deflects the forces which contain potentiality of trouble into innocuous channels of fantasy. Play thus becomes an outlet and a form of confession. At the same time it performs a function of integration, for by 'playing through' his emotional attitudes towards himself, the child puts himself in the place of the persons in his environment, tests the strength and quality of his emotions, as well as his control over them, and builds up his personality in the process, emerging finally as a more complete and better integrated individual.

These are the reasons which determine what may appear to the layman as an excessively earnest attitude of the psychologist to the child's play. In daily language, the expression 'child's play' has come to signify something trifling, unworthy of serious consideration. Yet any one who had watched a young child at play would realize at once how intensely serious and absorbing it is to the child. A deeper study would show that both the utilitarians and the hormists are correct in their interpretations of the function of play. It has educative, as well as enjoyment value, yet in a broader sense than either Groos or McDougall assigned to it. The child's learning through play is more subtle and more general than is implied in Groos's theory, and his acquisitions far less obvious. By playing the part of father, mother, engine-driver, or doctor, he acquires no knowledge of how to behave in these parts when he grows up. What he does achieve is the experience of imaginative identification and intuitive understanding: what he gains is not practical skills, but an inner balance on which depends his future emotional development and the success of his relationships with other human beings.

And as he plays, he relives, and reveals himself, for play, like everything in mental life, is influenced by what has gone before it.

CHAPTER II

'FATHER TO THE MAN'

THE truism that many great discoveries of modern science have been foreshadowed centuries ago by common-sense observation or creative fantasy is, for special reasons, less acceptable to the layman who sits in judgment on psychology than to the same person appraising the achievements of physics or medicine. The man-in-the-street is well aware that medicine or physics is the province of a specialist, and that a strenuous and prolonged training is required in order to enable him to pass valid judgment on particular problems presented by these subjects. With regard to the study of the human mind he has no such scruples: he assumes that he knows his own, and can, with varying degrees of success, read the mind of others. The accusation he raises against psychology is either that its contributions contain truths so obvious that their restatement is unnecessary, or are so fantastic that they cannot be believed.

That some less obvious psychological truths are nevertheless universally valid can be shown by quotations from the days when psychology, as a science, was non-existent. Dr. Johnson forestalled Spearman's postulate of indivisible mental energy when he told Boswell:

> It is that one man has *more mind* than another. He may direct it differently: he may by accident desire to excel in this study, or that. Sir, the man who has vigour may walk to the east, just as well as to the west.—(BOSWELL, 'Journal of a Tour to the Hebrides,' August 1st.)

and the Jesuits anticipated the claims of both the Freudians and the Behaviourists when they asked for the control of the first seven years of the child's life in order to form the character of the man.

Since psychology has adopted scientific methods of study and investigation, much evidence has been accumulated to support both statements, yet neither has acquired the status with the man-in-the-street which would put it outside the realm of controversial subjects. The emotional repercussions of psychological discoveries are too disturbing to the average mind to allow the matter-of-fact treatment meted out to physics or

physiology. Upon this are superimposed vague ideas of the inviolability of the human psyche, the sinfulness of 'experimenting' with human beings, and of the dangers of introspection. Out of all this a formidable system of defence is constructed, strengthened by many unconscious mechanisms, which makes the ordinary man pretty well impervious to psychological discoveries which fail to synchronize with his personal ideas of himself, his opponents, or his friends. Far more interested in keeping his peace of mind than in knowing the truth, he would interpret any such discoveries to suit his book, evading, maybe unwittingly, their less acceptable implications. He might repeat the well-known statement 'The Child is Father to the Man' in all innocence and without questioning its validity, but would smile incredulously when faced with proofs of the importance of the first few years of life for the formation of character.

Yet the poet who coined the phrase must have had an intuition, as poets frequently do, of much wider and deeper implications of his statement than the man-in-the-street would willingly accept. No doubt he must have meant that all the stuff, all the raw materials out of which character is fashioned, are contained in the mental potentialities of the infant, and that upon the way in which we handle these materials from the beginning the shape of the Man will depend.

HIS HUMAN HERITAGE

As in this book we are dealing with a subject which, in some of its aspects, is very new and provocative of argument, the need for making our premises clear from the beginning is particularly great. With what assumptions do we approach the child? What idea do we have of him? In which directions do we want to influence him? Both parents and society have the right to ask us these questions, and it is our duty to satisfy their legitimate concern.

Our views of the child's nature are the ones that have been widely accepted by students of human nature and incorporated into the general body of modern psychological knowledge. It may be superfluous to state that Locke's view of the child's mind as a 'tabula rasa' no longer finds any support among the students of psychology. All, including the Behaviourists, are agreed that certain innate potentialities are present from birth. Broadly defined, these are the capacities to know, to feel, and to act, and within each of them are contained certain more

specialized mental powers for acquiring different kinds of knowledge, experiencing a variety of emotions, and acting in a variety of ways. The work of Spearman[1] and of many others has shown that great individual differences in cognitive capacity exist from birth and are only slightly affected by environment. There is much evidence, although not so well substantiated, that individual differences in emotional capacity, both qualitative and quantitative,[2] are also innate, but, in contrast to the cognitive capacity, there are many indications that the influence of environment, especially of early environment, upon them, is profound and far-reaching.

In our approach to the child, we assume that he does not lack any of the innate capacities which the human species is known to possess. His emotional and instinctive potentialities are of a greater interest to us than his intellectual endowment, just because the development of character is so closely bound up with the development of emotions and sentiments. And of these, certain emotions and instinctive urges interest us particularly because of their primitive force, their biological importance and their tendency to conflict, in the conditions of our civilization, with other urges and emotions which society more readily sanctions by its approval.

We thus accept the evidence of accumulated observation that the child is capable of experiencing all of the commonly known impulses: fear, anger, curiosity, including curiosity about sex, affection, submission, self-assertion, possessiveness, disgust. If he shows an excess or a deficiency in any of them, we assume that this might be due either to his original endowment, to specific influences in his early environment, or to both these factors operating together—a problem to be settled by further investigation in each individual case. If we find, as sometimes happens, an apparent absence of any one of the primary emotions; if for instance the child appears to be incapable of affection, of curiosity, or of anger, we are chary of ascribing it to an innate lack of such capacity. However great are quantitative differences in individual capacities, their constellation remains the same in human beings as we know them. Imagine a human being who has never been known to manifest curiosity, anger, or affection—and it would be doubtful whether one could

[1] Spearman, *The Nature of Intelligence and the Principles of Cognition* and *The Abilities of Man.*

[2] Burt, 'The Factorial Analysis of Emotional Traits,' Character and Personality, VII, pp. 238–54, 285–99.

call him human. All that is found in the Man must be contained, however undeveloped, in the Child, who is the Father to the Man.

The child's emotional development is fraught with difficulties from the beginning, due partly to the nature of the emotions themselves and partly to the attitude of society towards them. Emotions seem to follow the principle of polarity and to form contrasting pairs: love—hate; anger—fear; submission—self-assertion; attraction—repulsion; an arrangement propitious to clash and conflict. Some of them are encouraged, others condemned and disapproved of by society in the persons of its representatives, the parents. Certain standards of social conduct and morality begin to be imposed almost as soon as the child is able to understand the gesture of prohibition or the sign of consent, that is, when he is still an infant at the breast. There is no doubt that the human child is innately predisposed to yield to this process of training or socialization, but when one considers the strength and complexity of his emotional urges and the very brief period of time in which he is expected to achieve their integration, his relative success in the task can be regarded as little short of a miracle. On the other hand, there is no danger in overstressing the fact that the methods by which such rapid socialization is achieved generally fall far short of perfection, and the resulting integration is often very unstable and incomplete. To use a hackneyed metaphor, a hastily socialized child is like a savage who has got himself inside constricting, outwardly respectable European clothes. Within them, the primitive mind lives on in a primitive body, either uncomfortably and unhappily subdued, or rebellious, ready to burst out of them at any moment.

The dangers of repression have been stressed so often that it might seem unnecessary to go into the subject in great detail. Yet perhaps no other doctrine of depth psychology has been the cause of so much misunderstanding and misinterpretation. As a result, the popular view arose that depth psychologists want to do away with all control, and a bogy was created of a completely uninhibited individual who does and says exactly what he likes. This bogy must be exorcised once and for all, for even if such a creature could be produced, which is doubtful, he certainly does not represent the ideal after which psychologists concerned with mental health are striving. Rather their view is that, even in the absence of all training and prohibition —if such a thing were possible—some repression would still

occur, for it is a device which is biologically most valuable. Repression, which is an unconscious process, needs to be clearly distinguished from conscious control of impulses, inherent in which is the human capacity for choice and renunciation. Without the capacity to inhibit conflicting impulses to action, thought, or feeling, which is inherent in selectivity, the whole of mental, as well as physical, life of the creature would be chaotic, and no sustained course of behaviour ensuring survival would be possible.

The real objection of the students of mental health to repression is that it is a crude and primitive method of dealing with inner conflicts, and should as soon as possible be replaced by the method of conscious and deliberate control. As long as our emotions remain polar in quality, that is, as long as man remains merely human, conflicts of varying strength between the opposing emotions, as well as the need for their control, will continue to be inevitable. Repression as a method of control has been aptly likened to government by a primitive form of dictatorship, instead of by an enlightened parliamentary constitution.

The comparison is Flugel's, who formulates the views on the subject with admirable clarity in his article, 'Freudian Mechanisms in Moral Development'. He indicates that there are three ways of dealing with conflicting tendencies: (1) Repression (of varying degrees of completeness), (2) Displacement (which includes Sublimation), and (3) Deliberate choice and conscious control.[1] Of these the first is the most primitive and is used spontaneously and unconsciously by young children and adults on earlier levels of individual development or belonging to more primitive states of culture. Displacement, or transfer of a conflicting emotion to some more neutral object, and sublimation, or redirection of the impulse into socially approved channels, appear, however, quite early in the life of the child and the member of a savage tribe. Both these methods of dealing with conflicting tendencies are, for obvious reasons, preferable to repression, which locks up, unprofitably, a great fund of mental energy belonging to the repressing as well as the repressed force. Sublimation should be encouraged, but it should be recognized that it is still an imperfectly understood and a very gradual process, and that capacity for it is limited and varied. It is likely to be more successful if expectations

[1] J. C. Flugel, op. cit. Br. Journ. of Psych. VIII, 1913, pp. 480–88.

and standards set are not too high in the beginning: mental life does not proceed in sudden leaps; it is a gradual unfolding. Even in such dramatic mental events as religious conversions the suddenness has been shown to be only apparent, and preceded by a long, generally unconscious period of preparation. A quotation from the same monograph would represent a good summary of our views on repression:

> If an attempt is made to repress too rapidly, too completely, or too extensively, then repressed tendencies are liable to find an outlet through harmful rather than through beneficial channels, because all the latter that are available have already been used up.[1]

It is thus the excess, the crudity, the indiscriminate character of repression that psychologists concerned with mental health find objection to, and which they seek to replace by the far more effective mechanism of deliberate choice and conscious control. Psychological workers in child guidance cannot but accept the view that many behaviour problems, as well as a variety of other symptoms, are brought about by an unresolved and repressed conflict between some powerful instinctive urges or emotions, just in the same way as neurosis is brought about in adults. The repression has been 'too rapid, too complete, or too extensive', and a displacement has occurred of the undesirable emotion or impulse to a habit, an activity, or a symptom which is to the subject less objectionable than the original urge. Problem behaviour or neurosis is thus a form of undesirable, unprofitable displacement, which should give place to sublimation or conscious control.

In treatment of adults this is achieved by a variety of analytical methods, in which the technique of free association is commonly utilized. For many fairly obvious reasons, this method is not suitable for the treatment of young children who cannot verbalize their emotions and thoughts in the same way as adults, and for whom monologue and discussion is a less natural way of expressing themselves. Play, however, is, and it is for that reason that play began to be employed as a method of diagnosis and treatment of problem children and that the term 'play therapy' has come into use.

[1] J. C. Flügel, op. cit., p. 488.

CHAPTER III

PARENT-CHILD RELATIONSHIP

'Les Enfants sont ce qu'on les fait'

VIEWS ON HUMAN NATURE

JEAN JACQUES ROUSSEAU believed that the child was born good, and that it grew into an unhappy, distorted creature because faulty upbringing perverted the all-round goodness of the Natural Man, of whom the Noble Savage was a shining example. The theory and practice of Froebel's educational method are in direct line of succession to those of the philosopher of Geneva. Maria Montessori's method is similar, although her theory is based on a different philosophy. There is no doubt that these methods of training through gentle encouragement of the child's natural interests, and an appeal to the child's innate 'goodness' have met with great success, especially when supported, in the case of Maria Montessori, by the influence of her own personality. John Watson, who sets the old French proverb as an epigraph to his book *The Child and the Magistrate*, seems to have achieved a great deal by applying this assumption to delinquent adolescents.[1]

The religious view is that, from the time of the Fall, incompleteness has become an integral part of human nature, and that Man requires Divine Grace to redeem him from original sin. The more extreme religious views, such as Calvin's, have taught the hopeless doctrine of predestination according to which some persons were born to be saved and others to be damned; the helpless playthings of the heavenly powers, they were marked out in their cradles for Hell or Paradise.

Modern psychology accepts man as incomplete with tremendous potentialities for good and evil, yet limited by his hereditary endowment. It recognizes the all-important part which parental attitudes play in the shaping of the character of their children, yet at the same time it accepts the existence in the child of an innate disposition which, although received from the parents, cannot be chosen or modified by them. Only in so far as would-be parents are aware of the importance of assuring sound mental make-up for their children, and are prepared to

[1] John Watson, op. cit.

be influenced by this consideration in their choice of a marriage partner, can they control to some extent their children's mental heritage. Clearly, this control could never be complete, for the chances of different combinations of the twenty-four male and female chromosomes derived from the two parents are almost infinite.

On the other hand the parents are well-nigh all-powerful in shaping their children's acquired attitudes, their social habits, their character traits, and the formation of their sentiments, including the highly important sentiment of self-regard, which forms the true nucleus of the human personality. The teachers who receive the child at five years of age are rarely able to alter or influence to any profound degree the foundations of character laid down in the pre-school years.

THE PARENTS' PROBLEMS

As for parents, they have to deal in the best way they can with the problems which the child's rapid development sets them at every step. They have to deal with them, as a rule, entirely unprepared, and without having received any training in parenthood, this 'most difficult of all professions'. The sentimental misconception of former days which assumed that every mother knew instinctively all the needs of her infant and how best to satisfy them has long been exploded, yet no serious attempt has been made to introduce training in motherhood into the curriculum of the modern school. Our age, which prides itself on being scientific and democratic seems to regard the upbringing of the human young as requiring less preparation than the breeding of cattle. Girls are taught to sew and cook, but not even the rudiments of mother-child psychology are imparted to them either before or after marriage, As for men, who, after all, have their part to play in the combined task of family upbringing, all knowledge which has anything to do with children is withheld from their education. This, incidentally, is in our view a big factor in neuroses in the male in our Western civilization, producing as it does a sense of non-fulfilment in one of his most fundamental urges. Many races, both primitive and highly civilized, allow the father much more expression of tenderness and affection towards the child, with the resultant real satisfaction and enjoyment in his offspring, which is a man's, as well as a woman's, birthright.[1] With our ignorance

[1] Margaret Mead, *Sex and Temperament in Three Primitive Societies.*

of the child's mind and our 'taboo on tenderness', it is small wonder that so few parents make a comparative success of their very difficult, but humanly satisfying task.

THE STARTING-POINT

When a child is referred to a Child Guidance Clinic for examination, it is customary to try to obtain as much information as possible about the circumstances of his early life. One of the things which the clinical worker wants indirectly to discover is whether the child was 'wanted'. However speculative and slight is the evidence for the prenatal influence of the mother's mental states upon the infant in her womb, we are unable to rule out definitely the possibility of such an influence. After having carefully weighed up all his data, J. A. Thomson still finds it possible to talk of 'the mysterious wireless telegraphy of prenatal life'.[1] It is well known that mental states influence the working of the endocrine glands, and the altered balance of internal secretions in the mother might easily affect the child *in utero*. But even without such an assumption, the mother's attitude towards the child after it is born is bound to be affected by her feelings before its birth. No doubt, most mothers who did not want the child at the time of its conception and during the period of gestation, accept it once it is born, but there is all the difference in the world between the attitude of eager welcome and one of resigned acceptance of the new-comer. Without attempting to analyse the reasons why the mother did not want the child, which may be many and complex, it is very probable that her acceptance of the child after birth could never be as complete and whole-hearted as it would have been if she looked forward to its arrival from the beginning. Her attitude could easily become one of ambivalence, that is of oscillation between rejection of the child and affection for it; and her affection might assume the form of exaggerated concern, even over-anxiety for the child's welfare and safety, as an unconscious attempt to compensate for unavowed hostility. There is no doubt that what a young child needs most is the security of consistent affection and tolerance from the mother or the mother substitute, and that he is likely to feel and be deeply and unfavourably affected by such powerful, although unrecognized fluctuations of the emotional atmosphere.

Being wanted is, thus, one of the basic conditions of the

[1] J. A. Thomson, *Heredity*, p. 163.

child's normal emotional development. By this we do not intend to imply that an unwanted child is bound to develop into a neurotic or a delinquent, for much depends on the sturdiness of the child's innate mental constitution. We would merely indicate that 'not being wanted', whether overtly expressed or merely implied by the parents, represents a handicap in the life of the child, with which he will have to cope from his earliest days, while the extent of its unfavourable effects will vary with the external circumstances and the innate disposition of the child.

THE TRAUMA OF BIRTH

The next point into which the clinic worker inquires is the circumstances of the birth itself. Was it prolonged and difficult, or comparatively easy? Were instruments employed? Were there any birth injuries? Again it is not assumed that the child's mental development is bound to be affected by the physical circumstances of its birth, but such circumstances are regarded as deserving careful examination. Otto Rank's theory of the 'trauma of birth' is not universally accepted even by the members of his own school of thought. He assumed that the experience of birth was in itself traumatic, whatever its circumstances, for birth meant separation from the mother, and the loss of perfect security which the child enjoyed in her womb. Then, by difficult birth the trauma would be greatly intensified, and the shock to the child's mind would be profound and lasting.

This view has been contested on several grounds, the most convincing argument being the biological. Biological writers have pointed out that birth is not a violent accident which brings the idyllic existence of the embryo to a sudden and brutal termination, but an inevitable sequel in the normal chain of events for which the creature has been prepared both physically and mentally. No doubt, like every important transition in the process of growth, it has its specific difficulties, but it need not become a trauma, any more than weaning or teething, unless it is attended by especially unfavourable circumstances. For instance, if the labour was long and difficult, and the child was born nearly asphyxiated, the distress resulting from this experience might conceivably affect the infant's subsequent reactions to his environment, although it is difficult to say how insidious or how permanent such effects are likely to be. On the whole, we strongly incline to the opinion that birth, no more than any other crises of life, need be accepted as an inevitable trauma.

FEEDING

The feeding of the infant is another subject of great interest to the psychological worker. It is generally agreed that breast-feeding is infinitely preferable to bottle-feeding in its effects on both mother and infant, but as a rule, its physical advantages are stressed more than the psychological. The analytical study of neurotic adults has brought into great prominence the importance of the feeding relationship between mother and infant. Its main findings are, perhaps, too well known to need repetition: to the infant, the milk-giving breast, the warmth and comfort of his mother's arms represent a world of security and affection which endures as long as the mother is prepared to keep it in being. Not that it is entirely in her power to do so. Occasional, periodic breast-feeding upsets are bound to occur with the variations in the mother's health and state of mind: the milk she is able to give might be inadequate in quantity or quality; the deprivation experienced by the child might arouse in him resentment and a sense of insecurity. The duration and strength of these reactions will again be partially determined by the child's innate disposition, but unless deprivation is severe and prolonged, we need not assume that its effects on the average child will be necessarily disastrous. Some deprivation is inevitable: if the mother is aware of what is happening and deals with it sensibly and sympathetically, she will help her child over a handicap which might otherwise distort the normal course of his mental development. Yet, it can easily be seen how an unwise or ill-balanced mother can increase the child's difficulties by an over-anxious, impatient, or callous attitude. She may be irritated or even angered by the child's refusal to take the breast, by its squirming and yelling; or she may be so distressed by the situation that she terminates it abruptly by providing some inadequate substitute, thus starting the vicious circle of continuous frustration. One of such psychologically harmful methods of dealing with deprivation is giving the infant a rubber teat to suck. This provides him with a vicarious satisfaction, but in itself is a form of deceit. No real satisfaction is derived from it, and the child becomes dependent on substitute satisfactions, which may give rise to compulsive habits in the adult. Such pleasures might also act as obstacles in his progress towards maturity. Real satisfactions must be in keeping with the stage of development at which the child has arrived, for instance, climbing around his pen, clutching,

rattling and shaking, even if alternately sucking, his ball, pegs, or toys.

THE MOTHER'S ATTITUDE

We must always bear in mind that the relationship between the mother and her infant is the most intimate, and his dependence upon her most complete. Gross disturbances of this relationship, such as the mother's dislike of the infant, her unwillingness or inability to give him the breast, could very well destroy the child's sense of security; and even minor frustrations or rebukes, which may appear trivial to a non-psychological observer, would, in certain circumstances, constitute a severe shock to the infant. Imagine, for instance, a somewhat impulsive, quick-tempered mother whose infant is beginning to cut some teeth, and whose nipple is suddenly and sharply bitten during feeding. There are mothers whose instant reaction to this is a hard slap: 'to teach him not to bite'. Needless to say, the infant learns nothing of the kind, for he is unable to isolate the act of biting from the complex of sensations which the feeding situation is for him, and to associate it alone with his punishment. He only knows that he has been enjoying himself, and that suddenly sharp pain has been inflicted on him. Then the shock of surprise and pain would be associated with the feeding situation as a whole, and would transform his small world of security and affection into a bewildering, topsy-turvy, dangerous place. Or it may happen that the biting was the result of an effort to draw milk from an unyielding breast; the punishment then would become associated with the striving for something which is desperately needed and desired, and yet inexplicably denied him. In either case the relationship between the mother and infant would be disturbed at the time when it most needs to be harmonious.

Security is the most pressing need of the child and the infant at the breast. The sense of security and comfort, as all of us know, is best communicated by this most direct and primitive of senses—the sense of touch. The child feels secure when it is held and handled firmly: an over-anxious, clumsy, or hesitant mother can arouse anxiety and restlessness in her child by the way she handles it. Whatever we think of Thomson's phrase about the 'mysterious wireless telegraphy of prenatal life', there is much to show that such direct communication of moods and states of mind from mother to child takes place at least in the child's early life. With this is bound up the intimate

interrelation between mother and child, including, in addition to his need of his mother, her own enjoyment of her baby, which the child unconsciously but surely senses. C. G. Jung regards the child's psyche as part of the parents' psyche: the young child has no way of escape from the influence of his parents' example and suggestion. This influence is not always direct and obvious: a fearful, timid mother does not necessarily induce timidity in her child: and when he is timid, the child may combat this tendency in himself, or even over-compensate by producing a façade of dare-devil recklessness. Yet it is highly probable that behind this façade he is concealing a host of irrational, debilitating fears.

Over-protection, of course, is not the sole cause of anxious timidity in children: the same syndrome can be created by the mother's rejection of the child, or her insistence on his being independent and self-reliant before he is ready to be so.

WEANING

In this respect physical weaning provides a perfect parallel to psychological weaning, for we must never forget that physical events in the life of a human being have their psychological counterpart. The weaning from the breast is to the infant not merely a change from the diet of the mother's milk to other foods: it is also the loosening of the most intimate bond with the mother, who, until then, has been to him the source of all things, good and bad, physical and mental. For that reason the psychological worker always inquires into the circumstances of the weaning in the case of children who need psychiatric help. Abrupt weaning may constitute a trauma, especially if at the same time the mother has to be away from the home for long periods: the child loses the warm security of her embrace, which he associates with food and physical satisfaction and has to adapt himself suddenly to an incomprehensible new environment in which a mechanical device is substituted for a personal relationship of the greatest intimacy. Careful investigations have shown that breast-fed children excel those who were artificially fed in every kind of achievement, both physical and mental. R. D. Gillespie, quoting C. H. and B. Rogerson, says that a sample group of breast-fed children was found to have a better appetite and to sleep better than a corresponding group of the artificially fed; that 'the incidence of enuresis, jealousy of a younger sibling, morbid fears and nervousness at elementary

school age' were significantly less among the first group, while 'their school records were significantly better'.[1] It is, of course, possible that the constitutional characteristics of the child might be partially responsible for the early feeding difficulties: it is far from easy to separate the effects of nature from those of nurture, for the interaction between the two begins as soon as the child is born. But with all allowances for the factors outside our control, we still stress the psychological view, which happens to be the common-sense view also: that the more gentle and gradual is the weaning, the less is the child likely to develop behaviour and other difficulties.

TRAINING IN CLEANLINESS

Toilet training is the next milestone on the child's journey towards socialization, and the next problem of upbringing for the parents to solve. The training directed to making the child 'dry' and 'clean' in our civilization with its stress on utilitarianism, begins early, perhaps too early for the child's ultimate good. A certain school of thought in the infant welfare world has spread the notion among mothers of all social classes that it is reasonable to expect the infant to develop regular toilet habits, to be 'clean' and 'dry' long before it can talk and walk. Competitions between mothers in the race for their babies' cleanliness are not infrequent. As a result, a disproportionate stress is laid on a function which is only one of many: the mother fusses, praises, blames, and punishes freely where she should be as unmoved and as matter-of-fact as any reasonable being is expected to be with regard to everyday routine. The study of neurotic subjects has shown that many cases of physical complaints and of objectionable character traits or neurotic symptoms can be traced back to the rigidity of early training in personal cleanliness. Just as food-fads in children and adults are frequently the consequence of unwise feeding and weaning in infancy, the common complaint of constipation and a variety of 'stomach' troubles are often the result of the clumsy handling of the child's bodily functions. It is no doubt less convenient for the mother to have a child who fails to establish regular toilet habits until he is two years old, or even older, but this inconvenience has to be weighed against the child's future mental health—a primary condition of happiness. And even after the habit has been established, the mother should be

[1] R. D. Gillespie, *Psychological Effects of War*, pp. 54–5.

prepared for relapses, which frequently occur on the arrival of a new baby in the family, or upon the child starting school; and she should guard against being unduly worried or distressed by them.

SLEEP

Irregularities in the child's sleeping habits can occur in infancy and persist into later years, causing much inconvenience and distress to both parent and child. There always will be individual differences between children, just as between adults, in the soundness of sleep and the quantity of rest needed. Having made this allowance, we still find that some children take an unduly long time to go off to sleep, wake up crying at all hours of the night, and are not easily pacified. When the possibilities of insufficient feeding, gastric upsets, and other physical discomforts have been eliminated, we should search for probable psychological causes of the child's restlessness.

A great deal depends on the emotional atmosphere of the home, and particularly on the mental state of the mother. A worried, unhappy mother may communicate something of her disharmony to the child by the way she handles it. Even if she is well balanced herself, she may reflect the atmosphere created by a truculent husband who cannot tolerate a child who sleeps badly. The family's sleeping arrangements are thus another important factor. Most students of child psychology and mental hygiene would agree on the desirability of the infant's not sharing its parents' room from the very beginning. This may be an ideal state of affairs unattainable for many hard-working parents living in a crowded home. But, *wherever possible*, separate sleeping accommodation for the children should be arranged for, as it will in the long run prove much less disturbing to both parents and children. We may reserve our judgment as to the frequency with which parental coitus is observed by small children sharing their parents' bedroom: records of neurotic cases have shown that many such 'memories' recovered during treatment proved to be fantasies. There is little doubt, however, that when the experience does occur, it is profoundly disturbing to the child, and that the significance of what is observed is appreciated, however vaguely, by much younger children than is commonly believed. A child of very early years may interpret what he sees or hears as a scene of violence, as an attack of one parent upon the other, as an injury being done to the mother. In an older child sexual curiosity and sadistic-masochistic

fantasies would be unduly stimulated. Apart from all the above reflections, the process of psychological weaning would be made easier and less of a wrench to the child if he is spared the painful experience of being 'exiled' from the parents' bedroom, by the simple expedient of never having had any claims on it. If the habit of sleeping alone is formed in infancy, the mother might be saved much future trouble, although she, or her husband, would perhaps have to suffer some inconvenience in the beginning through having to get up to the child during the night.

EXCESSIVE CRYING AND TEMPER-TANTRUMS

This brings us to the common parental complaint: the baby cries too much or too often: 'there seems to be nothing we can do to stop him'.

The practice of child upbringing being generally many years in arrears of the findings of modern psychology, a nurse of the earlier rigid school of thought would most likely reply to this complaint: 'Make sure that there's nothing wrong with the baby physically, then leave him to cry to his heart's content. On no account give in to him if you want to avoid further trouble.'

The modern psychological advice would be: 'Wait and see how persistent the crying is. If the infant does not settle down within a few minutes, make sure that he is not suffering from any kind of physical discomfort. If this is not the case—and it is not always possible to be certain—leave him alone for a few minutes if you like, but on no account allow the child to work himself up into a fit of uncontrollable sobbing.' To say nothing of the physical distress which such crying causes to the infant—sensations of strain, of choking, and of congestion about the head—the psychological consequences of such experiences, if repeated, have been shown to be disastrous. After all, crying is *the only way* in which a young infant can communicate his needs, wishes, and feelings. His needs, even at this early age, are not exclusively physical: he may need the reassurance of his mother's touch and presence just as much as he needs her milk. He is a social being, and enjoys a familiar face bending over him or a warm hand to clutch. From the age of a few months onwards his need for company is quite legitimate, and its satisfaction within reasonable limits is as important as the fulfilment of his other needs. To turn a deaf ear to the child's appeals for attention is to do him an injury: it is leaving him a prey to the emotions of fear and rage which he is, as yet, entirely unable

to control. Most normal adults know how alarming it is 'to lose one's head' in a fit of panic or passion: they will easily understand how overwhelming such an experience must be to a helpless infant. The infant's conception of the world is shaped by the treatment which is meted out to him: if he finds the world, represented by the mother, indifferent or unhelpful in his distress, he might grow up apprehensive and cowed, or hard and defiant, expecting punishment and prepared to inflict it upon others. He might develop an anxiety neurosis, or what is described in Freudian psychology as an intolerant, excessively severe superego, unable to tolerate failure or weakness in himself or in others. Clearly, no good purpose will be served by a method which achieves such results: a sensible mother of an average infant should be able to find a golden mean between the rigidity of the rule-of-thumb upbringing and the unwise compliance with the infant's every whim. She will soon learn to differentiate between the cry she must soothe and the cry she can disregard.

Temper-tantrums in the proper sense of the term do not occur until the child is sufficiently integrated to be able to assert his own individuality, that is until the age of eighteen months or two years. From that age onwards they may become fairly frequent and can be provoked by any obstacle, mechanical or human, to the child's intentions and wishes.

The psychological causes underlying the child's anger reactions to a situation he is unable to master may be several. About that time his own self, as distinct from other selves, is beginning to take shape in the child's consciousness, and healthy self-assertion is stimulated by an environment not unduly subservient to his every whim. Self-assertion, like any other primary impulse, when frustrated, gives rise to anger. It is an open question whether the infant ever really enjoys an undisturbed state of omnipotence, which some writers on the subject have postulated, and whether his rages are due to a discovery that his godlike powers have a limit. A more plausible hypothesis in our view is that the background of his consciousness is formed by an emotional awareness of dependence, and the 'sense of omnipotence' may be occasionally brought about when he realizes that his cries invariably result in the arrival of the mother who hastens to attend to his needs. But as even at that age some of his wishes are thwarted and his cries remain unanswered, his megalomanic delusions must suffer some rude

shocks. The infantile 'sense of omnipotence' is surely a misnomer: or rather an exaggeration; the infantile sense of power would be a more accurate term.

Whatever the cause, the effects of thwarting a child's self-assertion can be easily observed by anybody; and the parent will be much helped by an assurance that temper-tantrums, far from being exceptional, are merely a landmark and a sign of normal emotional development. A child who has never experienced them must lack an essential trait in his mental constitution, or has, from early infancy, been cowed into a state of spiritless submission.

It must be admitted that it is often easier for an outsider to deal with the child's temper-tantrum than for the parent, who may have provoked it, however unwittingly. The emotions aroused in a conflict between parent and child are so complex and so powerful that, unless the parent is exceptionally wise, a deadlock might ensue with dire results for the parent-child relationship. As Florence Goodenough's inquiry has shown,[1] the ways in which parents deal with their children's 'anger outbursts' are many and various, but there are many which are neither effective nor free from harmful influence on the child's character. Violent measures, such as hard spanking or putting into a cold bath, besides piling one shock on the top of another—for a fit of uncontrollable screaming can be regarded as a shock—merely persuades the child that might is right. The young child attempts to coerce his environment into submission by force; the parent controls him by similar measures: externally, the parent often wins, but internally violence is set against violence in an unending conflict. It might end, of course, in the child's will 'being broken'—an achievement of doubtful value, to say the least—but more often it results in psychological difficulties of many kinds, which will come later under discussion.

A method more in vogue at the present time is for the parent to put the child out of the room and 'let him get on with it', or banish him to his own room alone. As a result, the child screams himself into a state of exhaustion, and falls asleep, or is finally brought out, promising to be 'good'. What lesson he learns in this fashion is a problem for his future therapist to solve, but one may surmise that it is not of a very reassuring order. He is certainly not helped to control his aggression and

[1] Florence Goodenough, *Anger in Young Children.*

rage: he is left at the mercy of these powerful primitive emotions at an age when he is as incapable of dealing with them effectively as of holding in check a runaway horse. He may, of course, realize by dint of repeated experience that mental and physical exhaustion and the eating of humble pie are the only possible outcome of his costly battles with his environment, but it is more likely to make him fear and reject his emotions than to give him a mastery over them which is the mark of a civilized being. The experience of being overwhelmed by one's emotions is an alarming one to an adult, and must be very much more so to the child. A calm, gentle, but firm attitude on the part of the parent will be both reassuring and helpful to the victim of a temper-tantrum; and it is only by setting an example of self-control that the parent can really teach the child to control himself. At the same time, a healthy, opportune, reasonable outburst of feeling on the part of a parent often releases the child from too great self-condemnation of his own ill-controlled impulses, and helps him to a more friendly acceptance of his normal but swaying moods and impulses. There is nothing more maddening to a child than the attitude that 'nothing disturbs mother'. As D. H. Lawrence says in his *Fantasia of the Unconscious*:

> Children have an infinite understanding of the soul's passionate variabilities and forgive even a real injustice if it was spontaneous and not intentional. They know we aren't perfect. What they don't forgive us is if we pretend we are.

The fact that so many adults are deficient in control may be a reflection on the methods by which our own parents dealt with our emotional outbursts when we were young.

PERPETUATION OF PROBLEMS

An experienced clinical worker would confirm the observation that, in a very large percentage of cases, the parents of the children we treat have themselves been 'problems' in childhood. With surprising frequency, they mete out to their offspring the treatment they received from their own parents, or, in their anxiety to avoid their parents' mistakes, go to opposite extremes.

The case of Mrs. A. provides a suitable example. Her two children were referred to the clinic on account of persistent enuresis and excessive dependence on the mother. She herself

had been enuretic up to the age of eighteen and had suffered much punishment and humiliation on that account. She frankly admitted that she had expected her own children to be enuretic, and that her attempts at training them had been hesitant and half-hearted from the beginning. She had never been on good terms with her own mother, and so had made up her mind that her own children would never suffer from lack of affection, or any material satisfactions which affection could provide. And in fact she lavished both gifts and attention on them, thus increasing their dependence on her at the time when this dependence should have been growing less. The children, however, were unable to feel secure with her, for she herself was still overshadowed by her own childhood's fears and hesitancies, and her shame and inferiority connected with her enuresis in childhood. Far from being indifferent to their symptoms, as she professed to be, she was exasperated by them and never failed to nag the children and hold them up to shame for their persistent wetting, which occurred both at night and in the daytime. Her very love of them was Kronos-like in its devouring possessiveness. She had declared on more than one occasion that she could not bear the thought of their suffering, and would rather kill them than leave them behind if she were to die. She also confessed that she hated the prospect of their marrying and leaving her.

She found her children's dependence on her at the same time irksome and flattering. The girl, aged six, was completely overshadowed by the mother, timid, extremely inhibited and unable to express any self-assertion except through constant wetting, which was a symptom of both anxiety and revolt. The boy, aged four and a half, probably a more aggressive personality than his sister and preferred by the mother, mastered his mother by means of the same symptom and by refusing to leave her. The mother's attention was wholly wrapped up in her children, which had an over-stimulating effect on the boy and an inhibiting effect on the girl. Neither could bear to part from the mother even for a few minutes: settling them to the school routine had been an arduous task, and both had a screaming fit at the clinic when brought for the psychological examination. For some weeks after the beginning of the treatment the children vied with each other in demanding their mother's presence in the room when they were being seen separately by two different clinical workers. Both wanted to

leave the room several times during the interview in order to be reassured by the presence of their mother.

In this case the mother, in her eagerness to spare her children what she herself had suffered, compensated in the direction of gross over-protection, and thus induced anxiety and exaggerated dependence, with a consequent sense of frustration and resentment in the children, the repression of which produced their various symptoms. The psychological weaning had not even begun in the case of these children of six and four and a half.

The opposite mistake is just as common: an attempt on the part of the parent to wean the child psychologically, abruptly, and at too early an age. This attitude too often springs from the parents' own psychological difficulties, conflicts, or half-forgotten childhood experiences. The parent may still feel unacknowledged shame and concealed bitterness about some shortcoming or fault, real or imaginary, for which his own parents used to scold or punish him. He may see this fault mirrored in his own children, whether it is there or not, and chastise them for it, punishing himself in their persons, making an unconscious use of them as whipping boys. Or he may be emotionally bound to a stern, demanding parent, who remained a paragon and an ideal, and whose methods of upbringing he tries to apply in dealing with his own family. He may be aware of his attitude, or remain unconscious of it; in either case such reactions are much less likely to occur in persons who have learned to meet life squarely and adventurously and who are themselves reasonably mature and integrated.

We are, perhaps, justified in saying that the children's problems in very many cases are a repetition of their parents' problems, in the sense that they originated in or were prompted by the parents' attitudes. More than that, the parents' problems can often be traced back to their relationship with their own parents. Thus, inevitably, similar symptoms tend to perpetuate themselves in several generations, with a resulting sense of hopelessness and fatalism in every one concerned, unless the vicious circle is broken by the intervention of psychotherapy.

It is well to keep in mind this perpetuation of faulty family patterns and not to confuse such a sequence with hereditary factors—to do so accentuates the sense of fatalism and builds a barrier against acceptance of treatment and consequent freeing of the personality.

CHAPTER IV

BREAKING THE VICIOUS CIRCLE

THE CASE FOR ADJUSTMENT

VERY few people would dispute that good physical health is preferable to bad health, but no such universal agreement exists on the subject of mental health. This may be due to the novelty of the concept, to the fact that the ideal of mental health is less well defined in the minds of the general public than the idea of physical health, and that it has not been widely discussed, or in any way popularized, with the exception of a few attempts made by the less scientific publications. It would probably be true to say that only a small minority of the general public is at present aware that there exist gradations of mental health just as subtle as those of physical health, and that human beings are not to be divided into two sharply defined categories: the sane and the insane. All the intermediate cases tend to be regarded by the man-in-the-street as suffering from 'nerves'—a complaint which is tacitly assumed to be physiological, and amenable to treatment by medical means, although admittedly of a specialized kind. Obviously, the sooner serious efforts are made to remove these misconceptions, the earlier will opportunities arise for preventive work in mental health as contrasted with treatment of already existing maladjustments.

As things are at present, however, it is usually only the cases of long standing or severe maladjustment that the psychiatric or psychological worker is asked to deal with, which reflects the general reluctance to recognize that psychological help may be necessary or desirable. The child is either very difficult to manage at home or at school, is backward, truants, pilfers, lies, or fights excessively; or he develops some troublesome and irritating symptoms, muscular tics, obsessional rituals, such as hand washing or touching, fears, or bed-wetting. Usually, the child brought for psychological examination suffers from a number of associated symptoms of maladjustment which make his need for help fairly pressing.

In cases of gross behaviour disorders, especially those that are affecting society at large, such as stealing and wanton

destructiveness, little argument arises in the public mind with regard to the necessity for treatment, however widely opinions may differ as to its character. When, however, the child's maladjustment is of a less obviously anti-social character, and especially if it is of a subtle kind, which does not affect the routine of the school or the household, the question of treatment, or even investigation, if it arises at all, becomes debatable. In so far as the child is 'little trouble', it is admittedly difficult for parent or teacher to recognize that he may be suffering from an inner conflict or emotional disorder which needs straightening for his own benefit, as well as for the sake of others. The deep-rooted prejudice against 'tampering with the mind' here manifests itself. Only enlightenment and propaganda on the subject can moderate such views. But there are prejudices of a more controversial kind, worthy of argument, such as, for instance, the expression of a doubt that so-called adjustment is a desirable goal to strive for.

'Should we aim at adjusting every one?' Is not maladjustment, in some cases at least, a sign of a more sensitive, more delicately balanced nature, and would not such a nature lose some of its sensitivity and responsiveness through a 'better' adjustment to environment? Cannot maladjustment serve as a stimulus to creative effort and achievement, as it seems to have done in the case of some famous artists and public men? And—most crucial question of all—is not 'genius akin to madness'? By aiming at perfect adjustment, are we not running the risk of populating the earth with complacent mediocrities, and shortsightedly substituting for variety of character and originality of outlook and creativeness a narrow ideal of sterile individual contentment, devoid of the *Sturm und Drang* which make for a mature personality?

If genius were as common as neurosis, the subject might be argued on a different plane. The truth of the matter is, however, that although twenty-five out of a hundred in the general population can be regarded as neurotic, only one in ten thousand is a genius. Some authorities[1] put the incidence of neurosis even higher, so that even if one accepted the alleged correlation between genius and madness, there still would be a large proportion of individuals whose creative gifts would be in no way jeopardized by adjustment.

But perhaps the best answer to the criticism of adjustment is

[1] Cyril Burt, *The Subnormal Mind.*

provided by Terman's extensive study of a thousand gifted children[1] who were compared to an equal number of 'average' children, matched according to social origin, age, and sex. Of all the traits studied (fourteen in number), only in one—mechanical ingenuity—were gifted children found to be slightly inferior to the control (unselected) group. In all others, including physical health, social capacity and *mental* health, they were found to be superior to the unselected children. In fact, Terman described gifted children not as queer, fanciful, eccentric beings, but as 'the kind of child any one would choose to adopt'. These findings should dispose for ever of the invidious paradox regarding genius, as well as of the notion that giftedness is often associated with instability. *Some* genius may be akin to madness; *some* gifted people are known to have been unstable, but more than that we cannot say, and it is open to doubt whether a genius would have lost any of his greatness if he were less 'mad', or a gifted artist any of his creative power if he were less unstable. And one should beware of confusing instability with delicacy of mental constitution, that is, with sensitivity of intellectual and emotional structure. Sensitivity denotes fineness of perception and appreciation, often combined with a high degree of co-ordinated 'wholeness', whereas instability connotes an innate deficiency in the capacity for integration and can be found in the least sensitive of beings.

As a matter of fact, by far the greater majority of children we are called upon to help are neither geniuses nor highly gifted: they are children of average ability whose chief claim to our attention is that they are disturbed and unhappy, and add to the unhappiness of those around them. Their maladjustment is, thus, not due to the exquisite all-round sensitiveness of the creative artist, which opens up possibilities of manifold enjoyment, as well as of intense suffering. No doubt, such are sometimes found among our cases, but more often the sensitiveness of problem children is of a circumscribed rather than of a general kind, a sore spot rather than a delicate complexion, and needs a soothing ointment, not protective 'skin food'. It is generally clear from the history of such children that their maladjustment, far from being a stimulus to them, is a handicap, increasing in seriousness as the years go by. It is perhaps worth stressing the point that maladjustment in itself does not call forth creative powers, increase vitality, or stimulate

[1] Lewis Terman and others, *Genetic Studies of Genius*.

adventurous living and thinking—on the contrary, it dwarfs and depresses. Environmental difficulties to be overcome, mountains to be scaled and fights to be fought do stimulate endeavour and develop personality, but only if the individual is sufficiently free from hampering maladjustments to go out and meet them with courage and confidence.

To summarize, the case for attempting to help children to better adjustment is, in the first instance, one of relieving unnecessary suffering by resolving or alleviating their inner conflicts, as well as by removing symptoms; and secondly, of assisting them to this greater integration, which makes it possible for them to tolerate frustration better, and thus increase their capacity for happiness and fulfilment. Needless to say, the measure of adaptation possible of achievement varies with each child; 'perfect' adaptation may be an ideal for which we strive, but which is attained very rarely, if ever, and perhaps only by unusual individuals. This may, we hope, provide an answer to the insidious argument: that individuals who adapt perfectly to this very imperfect world cannot be wholly admirable, so why should we strive to encourage adaptation? The answer is that adaptation, although it takes as its centre this world and age we know and the period of history in which we live, is not so dependent on conformity to environmental and social standards as on the attainment of the individual optimum of personal fulfilment, potentially inherent in the young child, but marred, distorted, or deviated by one or other of life's experiences. This attainment or adjustment is relative and may be imperfect, but once achieved, facilitates the individual's happy and spontaneous acceptance of his place in time and space.

EXPLORATION OF THE CHILD'S PROBLEMS

The causes of the child's failure in adaptation are usually found to be complex, yet contained within his past history and his present emotional background, with his innate constitution providing the ground plan. The child may be innately less capable of tolerating frustration, or endowed with a greater than usual share of some primary impulse, such as self-assertiveness, fear, sex, or curiosity, while his environment may be peculiarly unfavourable to normal development and satisfaction of these impulses. In every case a most careful study of the child's history, including phases of early development, is

necessary to illuminate his character and the probable causes of his difficulties. Some of the important items of this study have been already mentioned in Chapter II. In the light of analytical studies and of Freud's discoveries, babyhood can no longer be regarded as a period of life in which unpleasant experiences do not matter because 'you forget all about them'. The very fact of forgetting has been proved to be illusive, and the most trivial experiences of infancy from the adult point of view, have been found to be woven into the warp and woof of adult character. That is why the psychiatric worker inquires about the circumstances of the child's early feeding, weaning, and habit training; an unwanted child, or a child who had insufficient milk at the breast, might show excessive demands on his environment, excessive aggressiveness, or a 'grudge' against the world; a child who had been too rigidly trained in cleanliness might develop obsessional traits of character, sadistic-masochistic tendencies, and an urge to unlimited power; a child who had been over-indulged, over-protected, or too severely checked and criticized, might become excessively timid, anxious, lacking in drive, and unable to hold his own in contacts with others.

The meaning of the child's particular symptom only becomes clear in the light of his previous history; the same symptom in different children may have a different meaning, or it may have several meanings even when displayed by the same child. Ubiquitous bed-wetting, for instance, can serve as an expression of two opposed emotions—fear and anger, or anxiety and aggression. Thus, Jimmy A., aged four and a half, over-protected and over-indulged by a very possessive mother, wet his bed profusely every night, and made scenes when, at the clinic, he had to let his mother out of his sight. He was not an anxious child, and it became clear during treatment that his wetting was a means of 'getting his own back' on his mother, of dominating her through his symptom, as she dominated him through her possessiveness. On the other hand, his sister, Gillian, aged six, also a confirmed bed-wetter, was very timid and anxious, and extremely insecure, owing to her mother's obvious preference and greater display of affection for Jimmy. For Gillian bed-wetting was a way of ensuring her mother's attention, a substitute for her affection, which she knew went chiefly to Jimmy. But with Jimmy too, wetting became a symptom of anxiety after the arrival of his baby brother, when he felt his position

as the favourite, younger child, seriously threatened. And for both children their symptoms, if viewed from a different angle, had the meaning of a power-gaining device.

Thus, every symptom, if examined, may be found to be a two-way pointer: it points towards the cause of the child's difficulties, as well as towards the goal he is trying to attain by means of his symptom. The child is, of course, totally unaware of the meaning of his symptom, and generally unconscious of his goal. His inner experience is, most likely, one of blind need, the fulfilment of which he feels to be obstructed, and for the satisfaction of which he strives by every means that his disposition and environment happen to put at his disposal.

The exploration of the child's problems does not stop at the careful study of his past history and his present family setting; it continues through the initial part of the treatment, and may confirm the original impression, or lead to new discoveries. The child's play is often most revealing in this connexion. Jimmy A. confirmed the aggressive meaning of his symptom by the extremely truculent, sadistic character of his play. For many weeks he spent the whole of his interview playing at battles between two contending armies in which all the soldiers on both sides were invariably killed, crushed by tanks, blown up, or drowned. The whole of this play was accompanied by grunts and exclamations of extreme satisfaction. His sister, Gillian, on the other hand, was reluctant even to touch toys, and would have been terrified of breaking any. Her emotional release some time later took the form of an orgy of messiness in sand, water, and paint.

The diagnosis, made at the beginning, thus may have to be reviewed after the treatment has proceeded some little way. Often the information, volunteered by the mother in the first interview, is incomplete, unconsciously biased, minimized, or exaggerated, and the complaint she makes about the child stresses some incident, or trait, which is comparatively unimportant. As more facts come to light in subsequent interviews, the picture of the child's difficulties becomes fuller and clearer. Thus David, aged five, appeared at the first interview as a fairly normal little boy, with perhaps more than a normal share of innate maleness and aggressiveness. He was referred to the clinic by the family doctor at whom he had spat during examination ('without due provocation' according to the doctor!) The mother's complaint was that David fought with boys in

the street too much and too violently; also that he attacked her bodily whenever she thwarted him.

For some weeks in the first part of his treatment David was the 'good boy' at the clinic, playing vigorously but constructively, and treating his therapist with all the politeness due to a 'lady'. When later he became more aggressive in play, several inner conflicts underlying the external situation became apparent. There was the conflict between the tender affection for the young, very feminine mother, and the jealousy of the big, strong, somewhat boyish father. This was borne out by the mother's statement that David was 'always so *loving* and repentant after he had been violent or naughty'. There was the conflict between strong curiosity about sex and the fear of discovering dangerous things about his parents, common in intelligent, observant, and discerning children. There was the clash between the masculine urge of asserting himself by force, and the tender, feminine side of his nature, which would rather gain its ends through affection and submission. There was strong anxiety about his own aggression, to which he reacted by increasingly violent and frequent attacks on his parents and strangers.

The integration of his many contradictory impulses took David nearly a year, during which his behaviour fluctuated between aggressive self-assertion and affectionate submission, until it reached a 'normal' level at which his self-assertion could be turned to constructive purposes. He had now found a balance between the two sides of his nature. None of his conflicts were obvious at the time of diagnosis or in the early part of the treatment, yet if treatment were not undertaken, David might have, later on, developed into a neurotic character, or a rebellious delinquent, for his mother was unable, without the help and advice from the clinic, to relieve his anxiety and give him security through wise and firm control and direction of his conflicting urges.

TREATMENT

Once the diagnosis has been made and the necessity for treatment recognized, it remains to decide what form the treatment should take in the case of each child. In our opinion, all deeper psychological treatment ought to be individual. Groups can be used to help children whose difficulties are mainly due to their environment rather than to deep-seated inner conflicts. Older children profit more by playing in a

group than the very young ones; 'only' children more than those who have already brothers and sisters to keep them company.

Although the subject of this book is treatment of children's difficulties through play, it may be appropriate at this stage to say a few words about other methods of treatment.

Analysis and persuasion are two well-known methods employed in treatment of adult patients, and these can be adapted for use with children. Obviously, both these methods are better suited for the treatment of older children, although children as young as five years have been analysed without the help of play.[1] With all younger children, however, it is far more expedient to use play as a method of analysis, instead of relying entirely on conversation, while language still is to the child a very imperfect tool. Whether play predominates or is only an adjunct to treatment, it is now accepted as the best method of access to the young child.

A process of analysing the child's play, determining its meaning and motives goes on throughout the play, and will be discussed more fully later.

In the treatment of children the same material is made use of as in adult cases, fantasies and dreams usually taking precedence over conscious reminiscences. These fantasies may be related in words, drawn or painted, or played out through the medium of toys in the therapist's playroom. As is well known, the distinction between fantasy and reality is often quite vague in the young child's mind, and many accounts of apparently true events may have to be treated as products of imagination, which, incidentally, in no way detracts from their significance. Therapy with the child has the same purpose as adult analysis or other methods of psychotherapy: to make the child conscious of his inner conflicts, to help him to face these conflicts by giving him reassurance and security, and finally to enable him to achieve a measure of inner harmony and stability necessary for a satisfactory adult life. The means employed for achieving this are the interpretation to the child of his play, his overt behaviour, his dreams and his fantasies, and the utilization of the personal relationship between the child and the therapist, sometimes referred to as 'transference'. Analysis is employed in preference to other methods by therapists belonging to the Freudian school of thought, but it is also used in more or

[1] Freud, *Collected Papers, The Analysis of a Five-year-old boy.*

less modified forms by 'eclectic' therapists to which group the present writers belong.

No child therapist would assert that all, or even the greatest part, of the child's play necessarily lends itself to symbolic interpretation. Symbols can be read into every human activity, but doing this would be a mere exercise of imagination serving no useful purpose.

Nor do many therapists attach a fixed symbolic value to definite toys or types of play. The meaning of the child's play is determined not by what he does at any particular moment but by the whole setting, including his life story and family circumstances. For instance, if a boy makes a large toy dog fight a small one, and the small dog wins, the therapist does not jump to the conclusion that he dramatizes his wish to fight and overpower his father. Yet if the therapist has weighty evidence to the effect that the relationship between the father and son is very strained, he is justified in making an interpretation in these terms, whether it is of value or not to communicate it to the boy.

A symbol-monger or a naïve psychology fan may well be warned against reading a symbolic meaning into a child's every action. But the student whom Professor Valentine quotes in his book[1] may not have been necessarily wrong when she remarked, as she watched a small girl in a nursery school persistently climbing upon tables and chairs: 'She's suffering from an inferiority complex: she wants to rise in the world'. The truth of this remark could only be disproved by watching the development of the child in question. There is little doubt that small children's climbing feats are often an expression of a wish to show that they are clever, strong, fearless, and successful; the child who 'feels small' either physically or emotionally is likely to use this as a compensation.

Treatment by persuasion makes use predominantly of the material easily accessible to consciousness, such as the child's everyday behaviour, and his relationships with his family, his teachers, and schoolfellows. The explanation of his symptoms is given in terms of conscious aims or evasions, and an endeavour is made to show the child that his present attempts at adaptation are inadequate. Direct advice is given with regard to other methods which are likely to prove more successful and satisfactory to both the child himself and to his entourage. The

[1] Professor C. Valentine, *The Difficult Child and the Problem of Discipline.*

child is encouraged to bring his problems up for discussion, and is helped to face them directly, and solve them, instead of evading them. It is hoped that by this process of 're-education' the child's neurotic attitudes and reactions will be gradually modified, until he finally achieves a better adjustment to reality. Therapists of the Adlerian school use this method in preference to the analysis of dreams and fantasy material, for they put the emphasis on the importance of social adaptation rather than on the solution of inner conflicts.

The general aim of treatment, restated in the light of what has been said before, is to achieve a better adjustment of the child to his inner, as well as the outer world. When this is effected, the child's powers can be used creatively for his personal satisfaction and all-round development as an individual. A better adjustment means a greater knowledge and acceptance of oneself, a greater capacity for tolerating frustration, and an increase in the capacity for living fully. It is obvious that any such positive alteration in the personality and attitudes of the individual would affect directly or indirectly all those who come in contact with him. The child's conflicts, unhappiness, and neurotic attitudes provoke negative, intolerant, or anxious reactions on the part of his immediate environment, with repercussions on a wider scale, spreading in concentric circles as the child becomes older and forms contacts with larger groups of individuals. Early in the process a vicious circle is formed: certain attitudes on the part of the child's environment become established which lead to the aggravation of the child's symptoms, and are, of course, confirmed by this turn of events. The more 'difficult' the child grows, the greater becomes the pressure of the environment, and the fewer the prospects of modification in the desired direction. The task of the therapist is to break this vicious circle by producing a change in attitude, first in the child, and then through the child in the parent, or whenever possible, by more direct means, in the parents themselves. Once this has been done, a way is open to possibilities of further development and creative adjustment, until finally a 'virtuous' circle has been established, and a hopeful, positive atmosphere replaces the former atmosphere of hopeless resignation or of sullen revolt.

THE ROLE OF THE THERAPIST

Much can be said on this subject, and many things that should be said may appear fairly obvious to any one acquainted

with depth psychology, and perhaps also to the more intuitive mothers, well endowed with common sense and understanding of children. Some of these things are, however, so important that we should not shirk from repeating them, lest they are taken too much for granted and thus lost sight of.

One of these important things is the attitude of tolerance towards the child, however 'naughty', messy, defiant, destructive, or hostile. Never should the therapist condemn, or appear to condemn the child for what he is, or does. He may have to restrain certain extreme forms of behaviour which usually, with skill, can be guided into other channels. Clearly, such detachment is far from easy to achieve; it can, perhaps, be achieved only through the therapist's own freedom from personal prejudice, acquired by means of his own analysis and of a wide experience of life. It presupposes an openness of mind, a humility and a preparedness to learn anew from each of his patients.

This tolerance and acceptance of the child's individuality has been misinterpreted by some critics as allowing the child to do exactly as he likes. Another erroneous view is to attribute improvement or cure of symptoms to the 'personal charm' of the therapist.[1] 'Personal charm' and 'a winsome way with children' are misnomers: what is thus described by the author is probably an inborn gift of easy rapport with the child, admittedly a necessary basic quality in every successful therapist. This rapport, however, is only the ground plan, and unless on this is built, through years of study, a workable individual technique in psycho-therapy, little can be achieved. Children, as teachers well know, are not affected by 'charm' *per se*. They are, however, well aware of, and instantly appreciate those, whether therapist or friend, who are capable of disentangling their problems, especially if they can do it through a medium natural to the child himself.

The therapist should also have the capacity for remaining passive and receptive for long periods on end, leaving the initiative to the child and accepting whatever part the child bestows on him. For any one who has had much experience of normal children, especially in the atmosphere of a crowded classroom with the ever-present necessity of enforcing discipline, the assumption of these attitudes may prove particularly difficult. Yet they are essential to the creation of the therapeutic

[1] Professor C. Valentine, *The Psychology of Early Childhood*, p. 181.

relationship, and the eventual success of the treatment, for the disturbed child almost invariably suffers from unconscious guilt feelings and is weighed down by criticism, direct or implied, from those who surround him and from his own 'superego.' He looks to the therapist for relief from this burden, and for reassurance that he is not, after all, as bad as he feels he is; that he can be liked and valued, despite his faults and imperfections. This was illustrated by a boy of ten, intelligent above the average, intensely curious about every aspect of life, whose interest in his body and in biological knowledge was frowned upon. He remarked solemnly: 'I do like here. It's a place where you can ask about and draw rude things, and not be prosecuted.' It was his way of describing the objectivity and tolerance of the therapeutic relationship.

But however important and effective is this relationship for the success of the treatment, there are forces of equal, perhaps of greater, importance acting in the child himself: the mind, like every living organism, strives to restore its health and balance where it has been disturbed. The therapist only helps to liberate the energies within the child's psyche, and to remove the obstacles which had accumulated in their path. He acts, in metaphorical language, as an accoucheur, not as a creator. The mind, like the body, 'cures itself', but it needs expert guidance to canalize its healing forces.

THE TIME-LAG

This unseen work which goes on in the mind of the patient after the stimulus has been given by the therapist, provides an explanation for the 'delayed effects' of treatment. It has been noticed that improvement in the child sometimes takes place not during treatment, but during a break through minor illness or holidays, or even after the treatment had been discontinued. The integration of the liberated inner forces needs to take place before the full effects of treatment can be observed, and the process of integration may continue for some time after the therapeutic interviews have ceased, just as the process of physical convalescence continues after the patient's temperature has returned to normal, and the physician has stopped his visits.

CHAPTER V

PLAY AS EXPRESSION OF CONFLICT

FREUD'S observation of a young child who played persistently with a toy tied to a string, which he threw out of his cot, then pulled in again, may have been the starting-point of a realization that play can have symbolical meaning and be used diagnostically.[1] The throwing out of the toy was accompanied by the word 'Gone!' uttered in a somewhat alarmed, startled fashion, while the pulling in was done with an exclamation of triumph. The obvious comment, of course, would be that play of this type is so common among young children, that to ascribe to it any symbolic meaning is to distort simple reality in order to make it fit complicated, far-fetched theories. This criticism may hold with regard to this type of play in children under one year of age, in whom it is probably no more than a part of a developmental process, and who display no emotion in connexion with the act of throwing, except satisfaction at having achieved it, and impatience when the object is not handed back to them promptly, so that they may throw it again. The child observed by Freud, however, was eighteen months old, and was known to be subjected to frequent and prolonged absences on the part of his mother; the emotions he displayed as he threw out and pulled in the toy were clearly those of alarm, followed by relief. In these circumstances it was justifiable to seek for symbolic meaning, which Freud interpreted as a dramatization of the mother's periodic disappearances and subsequent joyful returns. The child was, thus, using play as a means of getting rid of his inner conflict (of love and fear) by projecting it into action, and as remedy against his anxiety, by reassuring himself with regard to his mother's ultimate return—a pretty illustration of the double aspect of play, diagnostic and curative.

C. G. Jung was another of the pioneers who observed the play of a four-year-old girl, Anna, in its symbolic, analytical implications.[2] Since Freud and Jung, play has been used as an aid to treatment of children by Melanie Klein,[3]

[1] S. Freud, *Beyond the Pleasure Principle*, p. 13.
[2] C. G. Jung, *Collected Papers in Analytical Psychology*, 1916, Chapter II.
[3] Melanie Klein, *The Psycho-Analysis of Children*.

Anna Freud, Susan Isaacs, Margaret Lowenfeld, and many others.

The fact that play is the most natural means of expression for a young child should be so obvious as scarcely to need further elaboration. As was pointed out earlier, its functions are several; in this chapter we will examine those that are, for therapeutic purposes, the most important.

PLAY AS HELP TO DIAGNOSIS

We take for granted that a person who is physically ill will behave differently from one who is in good health—his looks also will betray his ill-health. A person suffering from nervous illness, however, may show nothing in his outward appearance, but his manner, his whole demeanour will reveal his mental state to the experienced observer. So it is with the play of a neurotic child: it differs from that of a normal child in many well-defined ways—his approach to toys, his behaviour during play, and the emotions which accompany the play all deserve close observation. His play may indicate both the type and extent of his mental disturbance.

Play may be studied both from the point of view of the choice of materials and from the nature and type of the play. Is it lively and freely expressed or over-solemn and inhibited? Is it at a level appropriate to the child's age, or is it immature and babyish, or perhaps over-sophisticated and dominated by grown-up standards? One can decide from the type of play whether a child is comparatively normal or disturbed, whether his disturbance is due to over-anxiety, excessive unresolved aggression for which he cannot find an outlet, or to inferiority and guilt which creeps even into his play life. A child with obsessional characteristics reveals such qualities in his pattern of play; an excited impulsive child, whose emotions run away with him and who shows a 'pressure of talk', will exhibit this same pressure in the tempo and variety of his play, which is characterized as a rule by an admixture of tension, restlessness, and lack of control.

A strong interest in certain play materials is common to both normal and disturbed children. Water, sand, clay or plasticine, hammer, and paints were constantly in demand at the Raleigh school.[1]

[1] E. R. Boyce, *Play in the Infants' School*, p. 35.

Many of them, especially the girls, insisted on water play for weeks at a time. Dishes, wooden utensils, plates, tea-sets, and bed-clothes all provided excuses to wash.

Water had enormous attraction for them all, not only for washing but for water play without a purpose. They enjoyed just pouring and dabbling . . .

Sand was never out of use. Castles were made with the purpose of 'bashing them down'. 'Puddly pools' were beloved, and the messier the mixture the more they delighted in it.'[1]

These same materials are used in the clinic and in addition dolls, dolls' furniture, including beds and cradles, bathroom sets, soldiers and all the smaller figures which can stand symbolically for members of the family and playmates. The selection and rejection of particular play materials, the choice or refusal of certain types of play are of significance in the diagnosis of the disorder from which the child is suffering.

INHIBITION

One of the most striking characteristics of the anxious child is a strong inhibition of play activity: we may find that such a child is unable to play at all. Placed in a room full of toys, he remains tense and rigid, seemingly incapable of touching any of them, or if he touches them, unable to do anything with them. The inhibition of play activity, needless to say, is not always a neurotic symptom: E. R. Boyce found it in a considerable proportion of her nursery school children, who came from very poor homes and had never had any toys.[2] Yet the very factors which had deprived these children materially may have starved them emotionally as well, causing a degree of superadded neurosis.

DESTRUCTIVENESS

Another characteristic of a neurotic child's play is the absence of constructiveness and the frequent presence of the opposite impulse, sometimes very powerful, an impulse to destroy. This again, within limits, is not abnormal: the same observer remarks that when, at her nursery school, the children were given freedom to do as they liked, 'there was at first an exceptional amount of destruction and aggressive behaviour'.[3] In fact, as might be expected, the same general trends would appear in the play of all children, but certain particular trends

[1] Op. cit., p. 31–2. [2] Op. cit. [3] Op. cit., p. 31.

would be more intense and persistent in the play of mentally ill children. Destructive and aggressive play is likely to continue indefinitely in a certain type of neurotic child, unless he is helped by the understanding reassurance and sympathy of his therapist. In the normal child there is a spontaneous gradual transition to creative play, as the same author points out.

> We look back now and smile at those first months, knowing how almost imperceptibly, order, relief and happiness came into the school. How law and happiness came about? There was no defined cause: the material and freedom did its work by providing the outlet for so many tangles and so much repressed energy.[1]

Such spontaneous recovery could take place even in disturbed children under similar conditions, if their mental disturbance were not too profound, and their feelings of guilt and insecurity not too acute, but recovery will be both more complete and more quickly attained by psychotherapy, and in the young child preferably by play treatment.

IMMATURITY

The neurotic child often plays as if he were much younger than he really is. A child of six or seven, for instance, would repeatedly put things in a box and empty them out again, or spend a whole hour filling receptacles with sand or water, as a little child of three to four years likes to do, pouring it out, and filling up *ad infinitum*. In this, again, 'normal' children, who had been deprived of opportunities for 'normal' play, resemble the neurotic. Miss Boyce found that at her school 'children of six and seven played the games usually associated with three- and four-year-olds'.

Thus, neither the level of play, nor the material the child uses, nor the nature of his play can be taken as a sure indicator of neurosis or normality. Environmental factors: poverty, cramped living conditions, lack of opportunity and toys may affect the child's play activities in such a way that the resulting picture resembles very closely the behaviour produced by mental conflict. Reversion to an earlier level and eagerness to use materials charged with emotional, primitive, symbolic significance, such as sand, clay, water and fire, is a feature common to all children whenever freedom in the choice and use

[1] Op. cit., p. 35

[2] Op. cit., p. 31–2.

of playthings is given them. Yet even when they play alike and with the same things, the differences in play behaviour between the 'normal' and the mentally disturbed become quickly obvious with practice and experience.

REGRESSIVE PLAY

A normal child, who had never had the opportunity or been allowed to handle earth, or sand and water, would gleefully make sand castles and mud pies at the seaside, and if in addition his early training in toilet habits had been over-strict, he might play with these materials with more than usual interest and absorption. A neurotic child, who has had some especially disturbing experiences in connexion with toilet training, if given opportunity for playing with sand and water, might be unable to interest himself in other toys or materials for a long period of treatment.

A case in point is that of Lionel W., a child of five, of high average intelligence. Lionel was a rather unusual looking child, very fair, with large dark brown eyes, and a pale somewhat pinched little face. His small body was rather overtopped by a large head. He had, however, a charming smile when his sense of humour was aroused, and he certainly had a sense of humour, although his usual expression was rather solemn and gravely watchful. He came from a working-class family and was the younger of two boys. His outstanding symptoms were aggressive and spiteful behaviour to other children, but later interviews with the mother brought out some further facts of his early history.

He had been severely rebuked and punished for an interest—common in infants—in the products of his bowels, his mother's reactions being anger, horror, and disgust. This interest, suppressed by the mother, was transferred to water which Lionel drank 'wherever he could find it', including the lavatory pan! At school his behaviour changed and he developed a spiteful, bullying attitude to other children.

At the clinic, with the exception of a short period of aggressive play and truculence towards the therapist, Lionel occupied himself entirely with water and sand during the whole of every interview lasting for three-quarters of an hour, for a long phase in the early part of his treatment. He showed little curiosity, and next to no interest in other toys, a number of which were to be seen lying about the playroom. Occasionally he would

pick up one or two of them, examine them, place them on the table, move them about, but after a few minutes, would invariably return to his sand and water play.

He took little notice of the therapist's presence, and behaved almost as if she were not there, differing from the 'well' child of this age who likes to share his play, at least intermittently.

Regressive play may be expressed not only in the materials used but in the type of play—the child in fantasy takes over the role of others, and constitutes herself the mother, the teacher or the small baby in scenes in which for the moment she lives, disclosing as she plays her individual conflict.

Pamela, aged five and a half, was a graceful, attractive little girl, delightful, imaginative, and with a sense of wonder about life. She spoke in a carefully modulated voice with exact phraseology and clear enunciation. She had been excluded from school for destructiveness, tearing up books, hitting and scratching teachers and companions. She could not mix with children of her own age and preferred the company of grown-ups.

At home fits of temper began to dominate the scene and Pamela changed from 'a little saint' to a difficult small girl. She was an only child of anxious parents who foolishly discussed her upbringing and their differences of policy in her presence. She had had earlier gastro-intestinal illnesses with alternating constipation and diarrhoea, and habit training had been accompanied by many tears on both the mother's and the child's part.

In her play during treatment after a phase of very correct grown-up realistic play in which she was the teacher, cross, intolerant, insisting upon high standards, and the therapist the child, subjected to autocratic government, her mood changed; she wished no longer to be the master and took over the role of the little baby, dependent, trusting, and affectionate. The high-pitched sharp voice disappeared, the crisp bell-like tones changed to a babyish wheedling note and a long phase of 'regressive' play was lived through. She would say 'I'm just a tiny baby at the kicky stage'. She lay on the floor, rolling about as an infant does, she made crooning noises, sang to herself and tried out baby words with missed consonants. She took the therapist's hand and attempted to walk—she liked to be wheeled in a baby chair. It is only when a child has sufficient confidence in her therapist that she can revert in play to an earlier phase of existence as this little girl did; it is a sign of progress in treatment and indicates that the small

patient has been forced to expect too much of herself and has been unconsciously imposing adult standards on a mind and personality which are still those of a child. The price of this forced maturity is neurosis; regressive play was one of the many roads to cure.

The destructiveness of the disturbed child differs from the destructive behaviour of a normal child not only in degree but also in quality, and has a special meaning for the individual child himself. A normal child would break his toys, pluck off heads of flowers, smash sand castles he had built, hammer and bang. He would do all that with some satisfaction, but there is no evidence that he exults over his acts of destruction, or is emotionally much aroused by them. Besides, he does not destroy persistently; within a short period, he would turn to constructive or imaginative play: make a tunnel, a bridge, build a house, sail a boat, or take tin soldiers for a drive on a lorry. He would break things up 'in order to see what's inside them', or because he is momentarily impatient or at a loss what to do next; often he breaks them experimentally, but hardly ever for the sole purpose of destroying them. If he shows regret at having destroyed them, or fear of punishment, these emotions are not exaggerated out of all proportion to the magnitude of the loss or of the transgression.

The neurotic child, if destructive, tends to destroy extensively, and gets caught up in his urge to destroy, seemingly unable to stop or to control it, or he may show no surface emotion in connexion with his behaviour, but underneath this apparent indifference there is evidence of strong feelings of guilt and fear expressed in tension, over-excitement and sometimes rapid fatigue in play.

Pamela expressed this frequently off and on in her treatment. Whenever she scolded the therapist in the teacher-child play, although outwardly in command of the situation, she shivered, stretched herself and would flush and pale alternately. She described these 'attacks' as 'my excitements' and herself volunteered that they were of two kinds, nice and nasty: the young child cannot verbalize its feelings accurately but this could hardly have been more clearly put. All adults know these two feelings—one a pleasurable excitement, the other an unpleasant state of tension, a border-line awareness of excitement spilling over readily into anxiety or apprehension. It was not until she was free of this apprehension and sense of danger that

she could allow herself to destroy in play, and later on to construct in keeping with her age and intelligence.

Often, however, the neurotic child destroys in order to test his parents' or the therapist's forbearance, not to see how far he may go, but as an appeal for help from an adult, as if to say 'how can I deal with my disorderly and frightening impulses?' or he may be asking for punishment which serves a double purpose: of allaying his feelings of guilt, and of assuring himself that retribution is not as dreadful as he had feared it might be. One boy remarked: 'You ought to punish me when I am angry, my mother always does; I like it better if I'm smacked when I'm naughty', with a look at the therapist which was at the same time appealing and anxious. Needless to say, often both these motives underlie the behaviour of the same child.

Ralph A., aged six and a half, a child of respectable, well-to-do parents, was threatened with expulsion from school on account of pilfering. The study of the case has shown that pilfering was only a development of 'difficult' behaviour which started soon after the birth of a younger brother. At the time of referral, Ralph had two younger brothers, aged four and two. He was said to get on fairly well with the youngest, but to torment the one next to him. In addition to pilfering of small objects at school, he was also exceedingly destructive at home: he tore the papering off the walls of his room, beheaded a whole row of geraniums in his parents' garden, tore up a patch of newly laid concrete flooring in the stables, and broke more than any parent could afford to lose.

His treatment at interviews began with a carry-over of his home behaviour. He smeared drawings made by himself and the therapist, then tore them up. Nothing he made was allowed to remain intact, nor could he enjoy or admire any of his handiwork; now and again there were pathetic attempts at making things, cutting out an aeroplane, or making a paper ship. These attempts were always given up in despair with the words: 'It's no good. I can't do it!' and finished with the destruction of what most children cherish—his own little bit of creative work. After twelve interviews, his mother decided to send him away to boarding school, as his behaviour at home showed little change.

This action, to some extent, symbolized her complete rejection of Ralph, which lay at the root of his difficulties. She was a cold, self-centred person with little capacity for warm feeling:

what affection she did feel went to her younger sons who were still 'sweet' and well-behaved. Ralph was a 'horrid little boy' and she confessed to regarding everything he did as 'naughty' and to an impulse to go on punishing him. He soon discovered that being 'naughty' was the only way he could engage her interest, and as he was a thoroughly masculine little boy, an innately aggressive, pugnacious child, it is not surprising that the form his symptoms took was destructiveness and direct attacks on his brother and his mother. At the same time he was really warm-hearted as most of these pugnacious youngsters are, and longed for his mother's affection: the conflict between his love and his resentment against her, added to the insecurity, which he must have felt quite early in life, owing to his mother's relative coldness and to the rivalry with his brother. His destructiveness was both a challenge and an escape: unconsciously and without words he was saying to his parents: 'Look, that's what I am like—you can do your worst to me, and I *must* know what your worst is like!' At the same time he was escaping from self-condemnation into punishment: his mother's rebuffs and frequent chastisement could mean only one thing—that he was, indeed 'a bad little boy'. His feelings of guilt were gratified by punishment, which thus stimulated him to more naughtiness. Destruction was, in his case, also an expression of despair: he had given up hope of making anything that was 'good'; the only thing left to him was to destroy. In this way was the vicious circle firmly established: the less his mother loved him, the more he was tempted to force her attention by destructiveness and aggression; the more destructive be became, the more she punished him and the more he was stimulated to seek further punishment. This is the ground plan on which is built the psychology of the delinquent and it illustrates the fallacy of purely retributive punishment in the rehabilitation of such young people.

Another significant sign in connexion with destructiveness is the intensity of emotion which the child shows. A normal child will show moderate pleasure in knocking down a sand-castle, but only a child who is emotionally disturbed will provide evidence of real 'wildness' in destruction.

Billy, a boy of seven, was referred by his mother—a sensible, placid person—for spiteful cruel behaviour to his young sister whom he bit and pinched, restlessness at school and inability to mix with other children.

Billy had a history of a difficult prolonged birth when he had to be artificially revived, a facial palsy at six months which necessitated his being propped up in bed from that age to twelve months, during which period he often choked for breath. He has had two attacks of bronchitis since.

He has an enormous and insatiable appetite, is at times aggressive and dominating with his mother and alternately dependent and clinging. He has had many vivid and frightening nightmares when he calls either parent who always go to him. At school he is intolerant of criticism and 'gets into a frenzy if teased'.

In treatment Billy showed much intensity of emotion accompanying his play themes—he was boastful and his talk was rapid and explosive. He began by making a large circular enclosure with high walls over which 'nothing could climb or jump'—inside the wall he placed wild animals; each approached in turn a gate carefully guarded by a soldier stationed at the entrance, with a machine-gun which shot them dead one by one as they came near the gate. This was accompanied by loud noises and whooping on Billy's part. He was a well-built boy, but plump rather than muscular, reported to be afraid of fighting with boys at school and very timid of physical hurts. He over-compensated for this by such remarks accompanying his play as 'Do you know I'm a tough Westerner—I don't eat ordinary food. I eat spanners and screws'. Another day he played war games, 'sticking' the enemy fiercely with bayonets and shooting them down with the machine-gun. During this type of play, he would go red in the face and show some of the frenzy described by his schoolteacher. A further theme was played out with a doll's house and a family of dolls. Billy put the family inside behind locked doors, placed guns at several of the windows and the father shot at all passers-by who came near the house. He again showed acute excitement, danced about, squealed and boasted of his great courage. In this way he was illustrating both his aggressive intent against the outside world of people all of whom he felt to be enemies, and his need to protect both himself and his family, the latter of whom stood for his security, against their fancied attacks.

Later in treatment as he became less recklessly aggressive, he played with the toys with less fury and speed and began to be absorbed in his story rather than its disturbing emotional accompaniments.

His dreams changed in treatment from nightmares—an outstanding one was of his mother's face being so far off that he could hardly see it—to nice 'smooth' dreams. Towards the end of treatment he volunteered that it was when he was frightened at school that he was most rough and bullying. There is no doubt that the boy's intensely disturbing fears began at an early age when his respiratory function was in jeopardy and he suffered a real physical threat to life.

His excessive talk, his boastfulness, the drive and destructive note in his aggressiveness both at school and in his play, represent both an outlet and a defence against the many fears that he has been subjected to in his life. As his fears diminish and confidence returns so does the quality and quantity of his aggressiveness decrease.

To summarize: a child, who regresses to the level of play characteristic of a much younger child and remains for a long time on that level; a child, who attacks or destroys persistently with concealed signs of emotion, or with a display of real wildness in destruction, and a child who cannot play at all, reveal by their behaviour that something in their mental development is seriously wrong.

The character of the play itself may, in addition, indicate the type of mental disturbance and give some clue to the conflict which lies behind it. Several examples are described below.

OBSESSIONAL PLAY

We all know the type of adult whose life is ordered by routine, who plans his day and allows nothing to disturb this plan: the meticulously clean housewife to whom order comes before comfort, the business man who is more interested in his card index than in the needs of his firm. Young children with these characteristics in the making avoid 'dirty' or messy play; they look anxiously for soap and water when sand play is suggested; they arrange toys in neat patterns, for example, half a dozen carefully fenced-in fields, each containing one father, one mother, and one baby animal. They dislike painting, and their drawings are dominated by the ruler, compass, and rubber. They may play silently or keep up a chatter of polite conventional conversation which acts as a screen to hide their deeper and truer feelings. Excessive fixity or rigidity is sometimes characteristic of their play behaviour: such a child seems unable to leave off playing with the same toys, or repeating the

same pattern of play. He may spend the whole interview making sand castles and destroying them, or mixing sand and water and putting it on plates; and he may return to these toys and these activities for many interviews on end.

Fantasy is sedulously avoided by such children at the beginning of treatment: they often look longingly at the doll's house and the family of dolls, then pass a remark that, of course, only small children play with these. One little boy of five told his therapist that he liked playing with dolls but 'only when he was a child!'

SCATTER-BRAIN PLAY

The child who is temperamentally unstable tends to go to the other extreme, and within the first quarter of an hour during an interview may handle practically every toy in the playroom and initiate half a dozen games. He would start this game or that only to drop it a couple of minutes later; he is constantly besieged by new ideas, but never carrying them through; beginning, but never finishing.

Alfred, age eight, was referred to the clinic for being 'beyond control', restless, jumpy, unable to concentrate, and domineering with other children. Here is a typical interview at the beginning of his treatment.

> All over the playroom all the time, talking and acting without a moment of indecision or repose. Shot sticks from a gun at first. On hearing voices outside, went towards the door to shoot at a worker outside. Got out all the tea things. Minced some clay for sugar and tea. Made tea and selected the best cup for the therapist. Drank some clayey water despite warning. Pretended he was a cowboy, and was going 'murdering'; then said he was shooting rabbits. Said he loved school, and his teacher was the best teacher in the world. Showed the therapist a purse he had knitted for his brother. Tried to shoot down a pile of bricks which would not collapse. Resisted leaving the playroom; knocked the bricks down violently with the butt of the gun, rushed to the crockery, and was about to sweep it off into a pail of sandy water. Had to be escorted to his mother in the waiting room.

Such play is characteristic of unstable children, but also of children in an acute state of anxiety. In the unstable it inclines to be more incoherent and purposeless. If a child is unstable and at the same time anxious, he may need to go on playing in this haphazard fashion for some time before he can be helped to

attain greater security and a relief from inner conflict. The change becomes evident in his capacity to settle down to more coherent and creative play. In the case just described the boy had attended the clinic for several weeks before he was able to concentrate on anything for any length of time, but finally, on his own initiative, he would spend a consecutive half-hour on painting a picture, or writing a letter to his father in the Forces.

HYPERACTIVE PLAY

A similar type of play which is always accompanied by excessive and pent-up excitement can be described as 'manic'. The excitement tends to increase as the play goes on, until the child would be on the point of losing control altogether. He may start by making 'a nice picture' in bright colours, then continue by mixing more and more colours, piling them on top of one another, splashing them over the table, and finally spreading paint all around him. Or he may begin by building 'a fine high tower', using up all the bricks he can find, then add anything he can lay his hands on, until the whole edifice threatens to collapse, and still he would go on adding and piling up. All this would be done with tremendous gusto, with laughter, squeals, and excited noises, but little realization of the possible consequences of his actions. It is at this point that the therapist brings her experience to bear in helping the child to understand his high-pressure impulses and the compulsive drive behind them.

CONCLUSION

Each of these types of play serves as an indicator of the child's innate disposition on the one hand, and of the character of the conflict from which he suffers, on the other. There can be little doubt that two children, one of whom plays silently, alone and with intense absorption, and the other who plays with boisterous over-activity, are likely to be constitutionally very different, just as much as Jung's introvert and extravert, or Kretchmer's schizoid and pyknic types are different. The child who persistently plays in 'scatter-brain' fashion will differ in character and disposition from the other two types, while his conflicts may be either similar or different. The type of conflict can only be discovered through the closer and more detailed study of the child's play.

It is, however, worth stressing that such neurotic symptoms develop into their specific pattern in the *home atmosphere.*

The treatment aims at effecting a change in the child's personality, but such a change is not likely to be permanent unless a considerable modification in the parents' outlook is also achieved, and their influence on the child is fundamentally altered. During the child's treatment, the parent is helped to a better understanding of her own, and the child's, problems by a trained social worker. One of the aims of treatment in all childhood neurosis is to improve the disturbed relationship between the parent and child, to make it easier for both to accept one another, and to reconcile them, although the way to achieving this may seem slow and devious at first. This reconciliation is desirable even if the parent falls short of our idea of what a good parent ought to be, and the home is far from satisfactory. In disagreement with the utopias of Plato and of the followers of Karl Marx, modern psychological opinion is almost unanimous in regarding even a very imperfect family as a more suitable home for a young child than the most perfect institution. To feel secure and emotionally satisfied the young child should have a feeling of 'belonging', something he can never feel in an institution, where no particular person claims him as his own. Such experience is traumatic for most children, and often results in a trait of emotional detachment, common among delinquents, and amongst persons who appear incapable of forming deeper affectionate relationships. It is only when the home is seriously harmful psychologically, or where the parents grossly neglect the child materially and mentally that the removal from the family would be recommended by a psychologist, and even then, placing in a good foster-home, that is, a substitute family, would be suggested in preference to an institution.

CHAPTER VI

THE WORK WITH THE PARENT

INFLUENCING ENVIRONMENT

TO say that the child must be adapted to, and within his environment is only a broad statement of policy. It does not mean that no attempt should be made to modify the environment which has intensified the child's inner problems of adjustment.

It would be true to say that by 'environment' most people understand the physical conditions in which a person lives: the degree of comfort in the home, the type of neighbourhood, the family's financial position, association with other families, and a number of other factors mainly external. From the psychologist's point of view, however, the mental aspect of environment is of more interest and importance.

This mental aspect is represented by relationships between the individual and those with whom he is closely associated: in the child's case between himself and members of his family, his teachers and schoolmates. It is not suggested that the physical environment in which the child lives can be dismissed as of no consequence, but it should be emphasized that the mental environment has much more profound and far-reaching effects on the development of personality, especially in the earlier years. A child may be happy and secure in a poor home, emotionally starved in the midst of luxury. Neurosis is by no means the prerogative of the poor; rather it can be said to ignore all distinctions of wealth and position. When one reflects on its origins—in the warring impulses and conflicts of the emotional life, one is not surprised at the ubiquity of nervous disorders. The younger the child, the more seriously is his mental health affected by his environment, and the more important is the part played by the relationship with his parents, especially his mother. The mother's attitude may greatly help, or practically nullify the therapist's efforts to help the child; so it is to the mother that the intermediary between the therapist and the parent—a specially trained social worker—addresses herself.

THE IMPORTANCE OF THE SOCIAL WORKER'S PART

The success of the child's treatment depends partly on the

interest which the parents, particularly the mother, take in his ultimate cure. It is the task of the social worker to ensure parental co-operation not only in the earlier stages, but throughout a long treatment, in some cases running into many months. The 'problem' child's parents very often themselves have problems, and in order to be fully equipped to deal with them, the social worker must have a special training, psychological and psychiatric.

The reader might wonder why an intermediary between the therapist and the parents is needed. Why should not the therapist interview the parents himself? There is a practical disadvantage in such a scheme: if the mother herself accompanies the child for regular treatment, the child would have to wait while she is seen, or vice versa. The alternative is for the mother to pay two visits weekly to the clinic which not many can manage. The therapist of course sees one or both parents when the child is brought for consultation and arranges occasional interviews afterwards at the parents' wish; to see parent and child together, too, is of supreme value for a diagnostic assessment of their effect upon each other, and this is always done, at least during the physical examination. Experience has shown, however, that it is prejudicial to the success of treatment for the therapist to be in open communication with the parent, least of all that he should see the parent every time the child comes to the clinic. This holds particularly for long-treatment cases.

The reasons for this need some elaboration. In the majority of children needing treatment, the relationship between the child and his parents is in some way unsatisfactory. Even if superficially it appears to be good, there are undercurrents of anxiety or irritation in the parents which communicate themselves to the child. When he is brought for treatment, therefore, the child is likely to fear a conspiracy on the part of the adults against himself; he feels that he is coming to treatment because he is not like other children, and in the beginning his attitude to the therapist is often apprehensive, suspicious, or hostile. The therapist's first task is to remove this defence which is often a reflection of the child's attitude to the whole adult world; only then can he win the child's confidence. When the child has given his confidence, either in words, or in play—by showing himself as he is with his real emotions and impulses—he is naturally anxious that his confidence should not be

betrayed. It seems true that because of his love for his mother and the fear of losing her affection, the neurotic child tends to conceal his real self from her more than from any one else. One is not surprised then that, during the child's treatment, mothers commonly complain 'He won't tell me what he does at the clinic'.

Children, no less than adults, have their reticences and most of them cherish a private life which should be respected by adults. This private life includes the child's personal imagery and fantasy, often vivid and highly individual, and it is out of this rich store that he builds up his personality—in great measure alone and without the intervention of adults. If he allows the therapist a peep into this world, he does so on the tacit assumption that no one else should be let into the secret, or through his intuitive appreciation that here is some one who will not betray him.

When, however, the therapist sees the parent without the child, the child naturally and rightly assumes that he is going to be discussed. The mother, he knows, will tell the 'doctor' about his misdeeds and transgressions. Will the therapist, too, betray him to his mother and will they together range themselves against him? There is little doubt that some such thoughts however vaguely, pass through the child's mind when he sees the therapist shutting himself off in company with the parent, for the majority of children show marked disturbance when the parents are thus interviewed. One small boy with a mother who could never forgive herself if she omitted one detail, kept knocking on the door during the interview. In the end he could contain himself no longer, rushed in, and burst into tears, saying, 'My mother always likes talking and now she is going to talk to you and use up all my time'.

Some children object even to the parent being interviewed by a person other than the therapist, but obviously in communication with him. An intelligent boy of five, seeing his mother walk off with a social worker as he was being taken to the playroom, remarked meditatively: 'I wonder what my Mummie talks to that lady about for so long?' 'What do you think she says to her?' 'I suppose she tells her what I've been up to.'

Yet it is obviously necessary for the therapist to know how the effects of treatment are reflected in the child's everyday behaviour and in his home circle. It is also necessary in the

interests of both parents and child that as treatment proceeds, the parent should be influenced in such a way as to make the child's recovery speedier and smoother. With younger children especially, the parent's handling of behaviour can be decisive in bringing about an improvement or in delaying it indefinitely. In fact, some child psychiatrists (John Bowlby) think that treatment of young children is not likely to be successful unless the mother can be influenced at the same time in a desired direction. Therefore, the therapist treating the child must be in constant touch with the parent, but in view of the specific relationship between the child and the therapist this communication must be indirect. Because of her early and intimate relationship with the child, the mother rather than the father tends to be the focal point in social treatment. This does not, however, mean that the influence of the father and his point of view are ignored, but only that for practical purposes it is, as a rule, the mother's responsibility to come for weekly interviews to the clinic, while the father is seen when it is both practicable and necessary for a wider appreciation of the family relationships.

The psychiatric social worker thus plays her part as a liaison officer between the child's therapist and his parents. She interviews the parent at the clinic. She visits the child's home before he is seen at the clinic, and records as full a social and personal history as it is possible to obtain. She also visits the school and supplements her knowledge of the child's character and behaviour by the report of his teachers: further visits of course are paid to the school for the exchange of additional information, especially if there are scholastic problems superadded.

Because she often has to deal with nervous or mentally disturbed parents, the social worker must be psychiatrically trained and this training includes an understanding of mental processes both normal and abnormal. Her task is to gain the confidence of the mother just as the therapist must gain that of the child; her objective—to hold a mirror before the parent so that in time she may see clearly and with tolerance the reality of herself and the child. To this end she encourages the mother to talk freely—at first about the child and his difficulties—later about herself and her upbringing, for anything she can reveal about her own life and her childhood will throw light on her attitude towards the child. As has been pointed out in Chapter

III, a mother sometimes projects herself or part of herself on to the child, ascribing to the child some of her own faults, fears, and wishes. Parents also may identify themselves with the child and attempt to realize their unfulfilled ambitions and longings through their children. It is possible for the social worker to detect these mental mechanisms at work and to convey their meaning to the mother which gradually brings about a change in her attitude to the child. The mother's relationship with her own parents is often revealing in this respect. She may be treating her child exactly as her own mother treated her, unable to break the bonds which bind her unconsciously to her parents. She may go to the opposite extreme; one finds this in the mother brought up austerely who indulges and over-protects her child, unable to impose a reasonable discipline, in her wish to give him all the freedom she herself was denied. Explanation and discussion of this kind may not only increase a parent's awareness of her own unconscious attitudes but may help her to see how unconscious attitudes can affect a child adversely.

Reggie J., an only child whose mother was tremulous and anxious, was described by her as 'so nervous he was constantly tripping and falling down'. They came to their visits clinging to each other, bound together in their mutual anxiety. It took several months before Mrs. J. could allow Reggie to walk alone, kicking stones cheerfully as small boys like to do.

EXPLANATION TO THE PARENT OF THE MEANING OF TREATMENT

The parent naturally wants to know what the child's treatment means, what are its aims, and in what way it is likely to affect his behaviour at home or at school. Many parents seeing the toys in the consulting-room are interested to know how toys and 'play' can be an aid in disentangling his problems. Every mother wishes her child to conform to a reasonable extent to his social milieu, but there are many who do not understand that a too rigid adherence to outer codes at too early an age may be crippling to the later development of his individuality. The 'too good' child is often misinterpreted and over-valued by parents and teachers alike, who fail to see in 'model' behaviour seeds of certain types of neurosis.

The task of explaining to the mother that many things the child does are not 'naughty' but occur naturally in the development of every child, falls to the lot of the social worker. She

also has to prepare the mother for the changes which are likely to take place in the child's attitude towards herself and other members of the family. Parents coming to the clinic expect a speedy improvement not only in symptoms, but in general behaviour as well, and have to be warned that the child may become more, rather than less, aggressive, noisy, or over-active on the way to final adaptation. During this phase, the previously 'over-good' child is particularly in need of tolerance and understanding from his parents. When parents expect an immediate improvement, they are prepared for the disappointment they may feel if this does not happen. They must be told that psychological changes are as slow and subtle as physical ones, that they become obvious only over a long period of time, and that it is difficult to hurry treatment if one hopes for a lasting cure.

While some parents tend to be pessimistic about the outcome of treatment, impatient with its slowness and adversely critical of psychological methods, others go to the opposite extreme and regard the child as 'cured' whenever there is a slight improvement in symptoms. The social worker's task in such cases is to modify their enthusiasm, to indicate that such miraculous 'cures' are often deceptive, and warn them that a relapse is to be expected when a change for the better has been too sudden. Even when the improvement has been gradual and steady, some parents wish to discontinue treatment because they are satisfied with the results already achieved, and cannot see the value and meaning of further attendance at the clinic; for instance when a bed-wetting child has become dry for a few weeks, or a stammering child can at last be understood. Even once-weekly visits are a burden to a busy mother, and unless she comes to regard the clinic as a valuable social and educative contact, she often anticipates too eagerly the termination of treatment. The difference between amelioration of symptoms and fundamental alteration of a disturbed personality has to be explained, making it clear to her that the gains must be consolidated and the 'cure' made certain before a decision concerning the end of treatment can be made.

Throughout treatment the child's confidences to the therapist should be respected, for the success of treatment can be greatly prejudiced by injudicious discussion of the play or talk of his interviews. This point is illustrated by the following incident

related to one of the writers by the child concerned in it. The story was told by a very intelligent delinquent girl of eleven who had attended for treatment in another clinic and had been told by her therapist that 'nothing she said of a personal nature would go out of the room'. She noticed, however, that the therapist was writing notes during the interview. That made her suspicious, and on one occasion she took a peep at the notes. From that time on she refused to co-operate in treatment. In the child's own words, 'She has written down everything I told her—from now on she'll have nothing from me'. The girl felt that she would be betrayed to some or other authority, and treatment had to be discontinued.

It is the parent who himself is a prey to conflict who cannot bear that the child should possess a private life of his own; parents of this type find it disappointing when the details of treatment interviews are withheld from them. To help the mother to accept the child's right to his reserves deepens her understanding of human values; it allays any jealousy, conscious or unconscious, she may have of another adult, in this instance, the therapist, to whom her child gives his trust; and it makes the child free to confide more in his therapist. Without this explanation and the development of parental objectivity, treatment may become impossible, for the child would build up defences against 'cure', as even young children can, while the mother goes on probing to know what happens at his interviews.

The mother's unconscious antagonism to the therapist's influence on the child would especially complicate his task of inducing the child to give up his neurotic defences. These, as analytical writers have shown,[1] serve the purpose of protecting the individual from inner dangers, created by his own conflicts and often imaginary or greatly exaggerated. These 'defences' have to be abandoned, for the protection they give is mainly illusory; their chief effect is to constrict the free development of personality, to fence the individual in, and thus bind and impoverish him spiritually.

HELPING THE PARENT TO OBTAIN INSIGHT INTO THE CHILD'S PROBLEMS

As is to be expected, parents differ greatly in their capacity

[1] Anna Freud, *The Ego and the Mechanisms of Defence*; Alfred Adler, *The Neurotic Personality*.

to understand and appreciate their children's problems. Retrospective imagination is a variable quality: memories of childhood are vivid to some adults, a closed book to others; insight into the child-mind also varies. Most parents have been doing their best for the child according to their lights, and are genuinely puzzled by the miscarriage of their good intentions. Others ascribe the child's difficulties solely to some extraneous factor, such as influence of bad companions, or to a definite event; separation, serious illness, or an accident. Still others are well aware that they have made mistakes in their upbringing of the child, and accuse themselves, sometimes over-severely, of having been too strict or too indulgent.

It is the task of the social worker, with her special training and her knowledge of all the relevant circumstances, to convey to the mother the real causes, often multiple, of the child's difficulties. By encouraging the mother to talk about her own childhood and her relationship with her own parents and her brothers and sisters, the social worker makes it easier for her to understand the child's attitudes and feelings towards herself. As the mother tells her own story, the social worker is able to gauge her relative maturity, her particular bias and her characteristic ways of dealing with the child; she thus gains further insight into the particularly complex interaction of factors which form the relationship between the two. It is this interaction which may be responsible for the creation of a vicious circle and the child's present symptoms.

A fairly typical situation is one where the child was not really wanted, but was accepted on arrival. The mother, repressing the feelings of guilt on account of her prenatal rejection of the child, over-compensates by showing exaggerated concern for his welfare. Her solicitude and protection extend to the most trivial details of his routine, and she feels endless anxiety whenever he deviates in the slightest from the normal. She watches his breathing at night when he has a slight cold and imagines he will fall a victim to pneumonia. If he strains on the lavatory she fears an abdominal obstruction. Such upbringing produces excessive dependence of a child on his parent, with mixed feelings in the mother of maternal satisfaction and irritable resentment towards her child.

George Y., aged six, was a little boy who illustrates these points. He was referred to the clinic suffering from excessive timidity, fear of dogs, tearfulness and 'grizzling' at home.

During play interviews he was hyperacute to sounds, jumped at the slightest bang, especially if he himself was responsible for the noise; he was anxious to please and placatory in his manner. His mother had never felt genuine affection for the boy; she was irritated by his babyishness, his timidity, his lack of grit, his poor physical health and frequent illnesses. George was a sensitive, 'highly strung', introverted little boy, not unlike his father in temperament. Mrs. Y. strongly resented her husband's inability or lack of desire to help her with George's upbringing, as well as the loneliness and isolation from social life which the care of George imposed upon her. As George grew older her disappointment in him increased, for he remained dependent on her, refused to go unaccompanied to school, and was unable to stand up for himself with other children. George felt acutely his mother's unconscious rejection of him and her open criticism of his shyness and sense of inferiority.

Not until the mother was helped to realize that her exasperation with George's timidity and 'grizzling' had its starting-point in her impatience with him when he was an ever-ailing infant, and made her his prisoner, was she able to see how this atmosphere was responsible for the formation of her son's character and the relationship between them. As a result of subsequent interviews she was able to connect her intolerance of the child with her own parents' impatience with her, and with the restrictive upbringing she had had which made her long for freedom and enjoyment—things which were not fulfilled in marriage because George's birth and poor health had made them impossible. She also realized that she was not giving George real, but a possessive, protective affection and that a fussing solicitude can never compensate a child for lack of genuine love. Not until Mrs. Y. saw this pattern more clearly and appreciated that she was imposing the same restrictions on George, could she welcome his increasing independence, the result of his treatment through play. As George began to go to school alone and showed more of the qualities of the 'real' boy she had wanted to have, she was able to give him some of the genuine affection he needed so badly and an altogether happier relationship grew up between the two.

Many parents, we have said, openly and candidly admit their more obvious mistakes in upbringing but few are able to appreciate the deeper causes of the neurosis. It is common for a parent to select certain errors which are comparatively minor

and unimportant, but to neglect larger issues which call for a radical change of attitude towards the child. Mrs. Y. blamed herself for 'giving in' too much to George and could not see that at the same time she had deprived him of all freedom. It is not unusual for a parent to fear that the child's symptoms betoken insanity. In her first interview Mrs. Y. said to the social worker with all the signs of desperate anxiety, 'George and I will soon be in a mental home'. Apparently she took no trouble to conceal this apprehension from George, for during his treatment he painted a picture of a man 'going crackers' and remarked that his 'Mum' often said *he* was 'going like that'. It took Mrs. Y. some time to realize how she had 'conditioned' George's character development by her apprehension and fussing, and made it almost impossible for him to be 'normal'.

ROLE OF EXTERNAL FACTORS

By stressing the mother-child relationship as a factor in the causation of the child's difficulties, we do not imply that external factors are of no importance whatever. There is no doubt that frequent and serious illnesses in early childhood, the separation of the child from the mother for long periods, accidents which the child experiences himself or witnesses can all be traumatic in a high degree and play an important part in the development of behaviour anomalies and symptoms of neurosis. Frequent changes of school also can be very disturbing to a child. All these factors, however, generally act as precipitating, not as original causes of the neurosis. Study of a number of cases has shown convincingly that hospitalization of the child at an early age is especially productive of emotional disturbance. At the same time it has been demonstrated that if the mother-child relationship was satisfactory to begin with, and the bond with the child kept unbroken by the mother's frequent visits to hospital, neuroses are much less likely to occur, and if they occur they are transient and readily assimilated into the child's whole experience of life.[1]

Through discussion and gradual enlightenment, the social worker helps the mother to place the external factors in their proper perspective, so that she does not unduly overestimate their importance, nor is she weighed down by a feeling of hopelessness and the fear that the harm done is irretrievable.

[1] H. Edelston, *Separation Anxiety in Young Children: A Study of Hospital Cases*, 1943.

It is a natural tendency in most people to regard external factors rather than inner tensions as responsible for their difficulties, to blame circumstances rather than their own methods of dealing with them. No useful purpose is served by apportioning blame to either persons or situations: parental errors are so often unconsciously determined, mistaken attitudes develop into family patterns and the child is influenced unintentionally. To convey to the mother the effects of such adverse influences without making her feel that she is being blamed, is one of the social worker's most delicate tasks.

HELPING THE PARENTS TO SEE THE CHILD IN A NEW PERSPECTIVE

Once the parent realizes that a secure trusting relationship between herself and the child is of paramount importance for the child's mental health, she must be helped to see in what particular respects this relationship has gone wrong. Some mothers immediately put their finger on the weak spot in training and often spontaneously produce it as an explanation of the child's difficulties. The mother of Paul, who is discussed later in Chapter VII, was quite aware that his symptoms arose out of his lack of companionship and 'mothering' in his toddler days; she knew this, but had not appreciated its import at that time, nor could she rectify its results later on without help and guidance.

In such cases it remains to the social worker to confirm and bring home to the mother what she had unconsciously perceived herself. In the larger proportion of cases, however, realization of the whole situation comes to the parents gradually, step by step. The crucial point is reached when the parents at last realize that a modification in their whole attitude to the child is essential. The goal has been achieved when the parent feels that day-to-day advice is no longer needed because, gradually, there has grown an awareness of new values in their family relationships which in future will guide them in most of the major and minor happenings in their lives. Direct advice in fact tends to be more and more rarely resorted to, for it has so frequently been found that even wise advice arouses contra-suggestibility in the parent, which might induce her to blame the social worker for subsequent failures, saying as some mothers do, 'You've told me to try this, and it didn't work'. Some mothers, especially the dependent ones, who cling

tenaciously to parental standards, and the over-anxious who cannot tolerate failure, are only too ready to accept an immediate change for the better in the behaviour of the child. Others who have been rebels against their own parents, resist, perhaps unconsciously, any advice which they consider savours of dictation. Both attach too much importance to external rules of conduct and fail to grasp that it is the parental attitude behind the words and gestures that matters most in upbringing. To avoid giving direct advice, yet at the same time to bring about a fundamental change in the mother towards the child's problems, is admittedly the most difficult part of the social worker's task.

To help the parent to see the child as he really is, and to accept him as such is one of the steps on the way to this goal. The parent-child relationship is so complicated by its peculiarly emotional character; the parents' assessment of the child's qualities and personality is so often distorted by their own unresolved complexes, that it is difficult for them to see their child objectively. The psychiatric social worker with her specialized training, her unbiased attitude to both parent and child, and her human sympathy, helps to increase this objectivity and widen the parents' perspective. At the same time she is in constant touch with the child's therapist who informs her of progress, of significant or outstanding steps in the child's treatment which are relevant to her work with the mother. On her side the social worker keeps the therapist informed of the emergence of additional points in the family history which are pertinent to the child's problems. Both therapist and social worker are thereby able to form an ever clearer picture of the family mosaic and the social worker is increasingly able to guide the mother towards a better understanding of her child.

The common failing of parents is to set their expectations too high, then to feel bitterly disappointed when the children prove unable to fulfil them. They react by becoming excessively critical and by failing to appreciate even the child's positive and valuable traits of character. The social worker puts stress on his assets in her conversations with the mother, at the same time trying to induce a hopeful and tolerant outlook with regard to his defects. As treatment progresses, the mother sees the child as he is, not as she would like him to be, and begins to value him as a person with an individuality of his own. As one mother remarked in surprised tones, 'I now see that his

cowlick is part of him, and without realizing it, I've stopped trying to stick it down'. The vicious circle of criticism arousing resentment and more difficult behaviour, and further misdemeanours calling forth further criticism and scolding, can thus be changed into a 'virtuous' circle, when the mother's tolerance makes it easier for the child to be 'good', and the child's 'goodness' arouses an appreciative response in the mother.

The close co-operation between the therapist and the psychiatric social worker has proved of such value in therapeutic work, that there is little doubt it is one of the important factors in success; as it proves its worth in wider fields, it will, no doubt, be used increasingly to facilitate child treatment.

CHAPTER VII

PLAY AS A METHOD OF TREATMENT

IT is a widely accepted view that neurosis in adults is due to the repression of unconscious conflicts, which then appear in consciousness in a distorted form, but there is some divergence of opinion with regard to the actual forces involved in conflicts of this type. The view of Freud is that the neurotic conflict is always between the repressed sexual wish and some other strong instinctive impulse. Adler favours the theory that the warring forces lie between the 'will to power' in the sphere of love, work, or community, and any inner obstacle to its realization, especially the 'inferiority feeling'. Jung's view is that the clash always occurs between the predominantly developed mental function, by means of which the individual had effected his adaptation to reality, and its undeveloped counterpart in the unconscious, its neglected opposite. The majority of psychologists agree, however, that any strong impulse, if repressed, may produce a neurosis by coming into conflict with ego or reality standards. The instincts of self-assertion and sex, especially, being the most powerful, the most strongly charged with emotion, as well as the least easily controlled, are regarded as the most productive of conflict.

The behaviour and personality difficulties of children can be looked upon as the beginning, the embryonic stage, the precursor of adult neurosis, and can be ascribed also to unconscious mental conflicts on the same basic hypothesis. One of the aims of therapeutic play is to uncover these conflicts, helping the child to become aware, step by step, of the origin of his symptoms. In this sense play is analogous to conversation and free association of the adult.

WHY IS PLAY OF SUCH VALUE IN THE TREATMENT OF THE CHILD?

A child, like an adult, possesses a mind capable of thinking, feeling, and willing; he, like his elders, makes use of speech to communicate with others, but as his ability to put his thoughts and feelings into words is still undeveloped, he finds some other method of translating them into a form which can be

apprehended by others, and enjoyed by himself. The child has a rich fantasy life which in his early years be can express in a lively, free, and vivid manner, and unless repressive forces are at work, can make use of it as a ready medium for emotional experience. All small children have a remarkable facility both in their talk and in their games for switching backwards and forwards from reality to fantasy—from their private, inner personal world to the outside world of objects and people. They also use toys and play to externalize their fantasies; to build up a world which is just as real to them as the world of reality. This fantasy life is richest up to the age of seven or eight years when the external world, community interests, and group games become more attractive. It is this capacity, this interest in play and fantasy, so familiar to parents and teachers, which the therapist utilizes for his ends in the treatment of young children. He knows that the child revels in play both with materials and 'make-believe', and out of this knowledge he has built up his technique of therapy through toys and fantasy and dramatic play. In adult treatment the unconscious emotional life is explored mainly through dreams and free association by means of conversation, but in the child a much greater variety of media can be used in therapy. The child-therapist makes use of such materials as sand and all the forms of messy play, toys, especially dolls in family groups, dolls' houses and dolls' furniture, animals, soldiers, and building materials, as well as clay, plasticine for modelling, and paints and pencils. He explores the child's dreams too, but finds the child more ready to draw or paint a dream or to act it, than merely to relate it in words. So many children begin with the recital of a dream, and, caught up in their daytime fantasy, confuse the two, and produce a composite story, often a valuable index to both the conscious and unconscious personality.

Harry, a little boy of nine with one small sister of four, dreamt he was all alone in a house which caught fire, but he escaped. This happened during a series of heavy air raids on London of which he professed to be unafraid. As he talked of the dream he drew it, adding 'and she said it was a lot of nonsense going to the shelter'. Therapist asked how this fitted into the dream. Harry then explained that during the raids he and his sister were put into the Morrison shelter, and his mother stayed in bed upstairs, thinking that Harry had no fears alone in charge of his small sister. On questioning him, he

admitted his anxiety and his shame of confessing it. The dream brought forth this series of associations on the basis of which a change in sleeping arrangements could be recommended to the mother.

THE SETTING OF THE CHILD'S PROBLEMS

The child's problems have a triple setting, which must be taken into account by the therapist. First of all there is his environment—the material and emotional background in which he lives. He may have many toys, but no brothers or sisters or companions to share his play. His mother or nurse may restrict his play to suit adult comfort rather than childhood needs; his parents may be at such cross purposes that it is impossible for him to lose himself contentedly in his toys and games. Secondly, there is his temperament, his disposition, his inheritance of physical, intellectual, and emotional qualities; this is the heritage which he will take through life. These constitutional endowments—physical and emotional—can be somewhat modified by education and by psycho-therapy, but cannot be essentially altered. Neither the pedagogue nor the psychologist can change the colour of our eyes or our fundamental body build, but both can modify our outlook on life and the way we handle the stuff of which we are made. Certain children lack sufficient basic capacity for integration and are not suitable cases for psycho-therapy. Much, however, can be done by adjustment of their environment and by education of their parents or guardians to understand them more fully. One can determine something of this innate make-up in the type and quality of the play in the first interview, as was demonstrated in the last chapter. Thirdly, there is the reactive personality—this is the combination of qualities the child presents as a result of the interaction between his unique temperament and the environmental influences which have moulded him. Mental environment, that is, the parents' and siblings' attitudes towards each member of the family never can be absolutely uniform, any more than the innate mental endowment of children belonging to the same family can be identical. This accounts for the individual differences in the development of siblings: if neurosis develops, each child may present symptoms of a quite different type. One may become enuretic, another may truant or steal, a third may remain totally unaffected and free of symptoms.

In play, one can take the measure of the child in these

three fields. The child unwittingly gives the therapist a fairly faithful picture of his environment in his first few interviews; and the very young child sometimes in one interview. Susan, a high-spirited little girl of three whose father was on active service, and whose mother lived in a flat where the child was constantly hushed and restrained, went straight to the dolls' bed in the playroom, made it up and put a small boy to bed. The doll fell out of bed repeatedly with a loud noise. Susan picked it up each time, scolded it and replaced it saying 'smack boy!' The therapist suggested perhaps it had not meant to fall out. Susan with emphasis—'Oh! it wants to fall out and be hit, then it can do it again.' This illustrated both her own fear of noise, the aggression which this fear aroused—which she projected on the doll, and her desire for punishment to atone for any noise she had made which she knew caused distress and irritability in her mother.

In the first few interviews, the therapist can determine whether a modification of environment will do all that is necessary—he can assess the child's fundamental make-up and from the content and type of the play make the important decision whether an intensive exploration will be essential before recovery can take place.

There is always a certain proportion of cases which come to Child Guidance Clinics which will not respond to simpler environmental measures, such as transfer to a different school, relaxation of a too rigid everyday routine, or the provision of greater freedom and opportunities for creative play. The distortion of personality and the severity of the symptoms in these children are such that only intensive psycho-therapy, involving an investigation of the whole emotional life will have any value in either curing the symptoms or effecting any radical change of personality. This group of cases is the province of the experienced child therapist who has made a study of 'play', and uses it as one, but not the only one, of his tools in the exploration of conscious and unconscious factors and the elucidation of the meaning of symptoms. Parents can take satisfaction in the thought that only children with a reasonably stable make-up, a fair intelligence and a certain degree of insight which includes such qualities as intuition and self-awareness, are suitable cases for deeper treatment, and that no experienced therapist embarks on long and intensive 'play treatment' unless the child has a sufficiently balanced personality to ensure that therapy will be

beneficial. It is part of the training of the child therapist to select cases on this basis, and the play of the child in the initial interviews is one of the criteria by which he makes this selection.

PAUL—AN EXAMPLE

The child described below illustrates this threefold investigation. Paul, aged seven, was a big boy for his age with a thick crop of dark hair, glowing brown eyes, and a habit of stumbling over furniture and losing his cap and purse. He was zestful and exuberant—he was an inveterate and loud talker and full of boundless energy. He was referred for enuresis, infrequent but furious bouts of temper and backwardness at school. This latter was not due to lack of intelligence, which was high, but to dreaminess and forgetfulness.

At first he was cautious and guarded in what he said, but expressed himself vigorously and freely in play. He elected to draw—'Let's do terrific, frightening pictures'! He drew rapidly with thick heavy lines and much splash of colour: describing it as a house on fire, he explained, 'There are 1,067 people in it, all burnt up—even if you go near it you are burnt to bits'. A second drawing was of 'a hot day'. 'It's such a bright day, the sun has a gleam in it, and it comes so low it gives out a spark and sets all the grass on fire and it spreads to the houses.' This was a good introduction to the hazardous world of his imagination, but its detail illustrates the warmth, vividness, and vitality of this boy's nature. He noticed the blocks, said he would like to build a house—as he did so he shouted enthusiastically, 'I've got a lot of new "shivery" plans to build a high castle'. Thereupon he stacked blocks in tiers on top of each other to impossible heights, and a fantasy story emerged as an accompaniment to his play. He himself 'lived' in a room at the very top of this castle, his parents, brothers, and sisters half-way down and therapist on the ground floor in a bricked-in shelter—'You will be safe there'. Here one recalls a little boy who refused to disclose his dreams to the therapist saying, 'If I talk about them then you might go having them yourself, then what would I do?' Children like to feel assured that the therapist is immune from the terrors that besiege them. Paul said he was on duty at the top to watch half the world and see it was not bombed, an overwhelming task for a small boy, and added that it was so high up there he had to have oxygen. He remarked shuddering, 'Don't you think I'm frightfully brave living so high up?'

This precarious edifice always swayed and swayed and crashed to the floor, with many loud excited comments from Paul. He usually escaped by parachute from his look-out, a good prognostic sign in that he possessed the latent capacity for dealing with dangerous situations and would do so later in reality as he now was doing in fantasy. Some children with less vitality and healthy drive than this boy are easily cowed by life's difficulties and exhibit this defeatist trait in their play. Discussion of bravery and fears brought a new fantasy personality into the play. This was Jonipher. 'He is a boy who lives in a land called Nowhere; there are burglars there who steal and put people in chains all for nothing. Jonipher was out cycling with his mother when he was taken there and it's three years since he saw his mother. He is a boy who is very frightened of being killed.' 'My mother wouldn't like him, she likes brave boys.' 'When Jonipher was frightened once, he screamed so loudly that two houses came down, the hinges came off and a whole street was twisted.' This probably demonstrates how beside himself with anger and fear, Paul had often felt.

Jonipher kept coming into the play always as a contrast to what Paul expected of himself—one day he said, 'Jonipher looks big and strong but actually he can't hurt a flea—he is very soft and likes to live low down in the castle, but he doesn't wet the bed'. Children so readily demonstrate in play what they cannot tell us in words: that bed-wetting was the price he paid for the high standards he was imposing upon himself and that Jonipher being less critical of himself was free of the symptom.

Paul then bombed the castle; he liked to drop his bombs from a great height and showed great satisfaction in the complete destruction of the castle and every one in it—as a final aggressive gesture he would dance on the blocks and kick a few into the corners of the room. His anxiety at the strength of his destructive feelings he transferred to the therapist by the remark frequently expressed, 'It's fierce isn't it—how are you *not* enjoying yourself?' To make his castle doubly safe he built it at times on a foundation 'nineteen miles deep with seven basements', illustrating his unconscious longing for a greater security in his relationship with those he loves and in his own inner life.

This child as a toddler had mistakenly been brought up not to show any feeling, neither anger, nor rebellion, nor

warm affection. He was put into his play-pen alone and was neither fondled nor played with. As play treatment shows, he was well endowed with strong feelings of every kind; it is not surprising that he later reacted by developing nervous symptoms. Because no tenderness was shown him as a little boy, not through lack of regard but on ideological grounds, he felt there was nothing in him to love, and a self-condemnatory attitude towards himself developed; he began to make demands on his mother through tempers and aggressiveness, but at the same time was over-generous to his brothers and sisters as though to expiate for his own naughtiness. He began to feel he was different and alien to the rest of the family, therefore he repressed his own individuality to conform to the family pattern. A sense of aloneness developed, enuresis expressed his longing to revert to babyhood, and his bottled-up, primitive feelings found their outlet spasmodically in tempers. As treatment proceeded, he took to sharing a 'look-out' with his father half-way down the building which by this time was of a less dangerous height. He was no longer adversely critical of himself for needing his father, and his false standards of independence gradually disappeared. Once the child is made conscious of his conflicts as this boy was in a long play treatment, his fears of his 'dangerous' impulses are lessened, his personality becomes more unified, he begins to see himself as he is, not as his parents had expected him to be, and he is better able to control his impulses or direct them into more acceptable channels. Repression no doubt is a form of control but it is blind and summary compared with conscious control. This boy presented a clear-cut picture of his environment in his castle-building and accompanying remarks: his play demonstrates his fears of losing his mother's regard, and his longing to be as strong and independent as his father; it expresses his shame at showing emotions, especially anger, love, and dependence on others, the outcome of the false standards of his upbringing. His type of play, his ability to rectify hazardous situations and his general demeanour were a clue to his temperamental traits, and the progress of his play and the phases he worked through exemplified the changes of personality structure as treatment proceeded.

This child (Paul) was endowed with high intelligence, good understanding and a rich imagination. Fantasy played a large part in his treatment. Many younger children, on the other

hand, talk little but make use of primitive material, often the same material to express more than one conflict, similar play taking on different meanings as treatment progresses. Lionel's phases of treatment demonstrated this.

CHANGES IN MEANING OF PLAY

Lionel, aged five, mentioned in Chapter V, spent the whole of each interview at the clinic, week after week, playing with sand and water. At the first few interviews, he showed extreme eagerness to come to the playroom. This changed to pronounced hostility: when fetched from the waiting-room, he refused to come, gazed sulkily at the therapist, and raised his hand as if to strike her. A few more weeks passed, and his attitude, although still hostile, became also playful: he smiled as he shook his head, refusing to come, and the threatening gesture was obviously meant as a joke. He would say to the therapist: 'You go first!' and, as soon as she was out of sight, would follow her at a run. Finally, after a fairly long period of treatment, he seemed to accept the therapist as a friend, and signs of hostility vanished completely.

His mother was an intelligent woman of fiery disposition who had a grudge against life, for she had been lame from childhood as a result of a T.B. hip. Lionel resembled her in temperament. She loved him deeply, but in her training of him had been impatient and sometimes violent; early in life he had been severely rebuked and punished for showing what is common in infancy, an interest in the product of his bladder and bowels. Children who are uninhibited ask many questions and show a natural curiosity in both bodily excreta and functions: they take a certain personal pride in what 'their bodies can do' and this natural curiosity should not be frowned upon. Lionel's sand-and-water play in the first stage of his treatment described in Chapter V, was mainly an expression of the repressed earlier excretory interest which he, for the first time, could satisfy fully, although in a symbolic form. His eagerness to greet the therapist was, at that time, merely gratitude for being allowed to play out his forbidden theme. Yet the unconscious memory of his mother's punishment and scoldings for such behaviour in the past, stimulated feelings of guilt and caused a conflict between the primitive impulse to satisfy these interests and the fear that it was wicked to do so. The mechanism of the crude superego, the unconscious controlling

factor, came into play: the condemnation of himself for indulging in 'dirty' play was projected on to the therapist: she was the wicked person who allowed, nay, even encouraged him to do wrong things. Hence his hostility towards her, which also served as a vehicle for his resentment against the mother who had checked him so sternly in the past.

When Lionel was about half-way through his treatment, an important change occurred in his family situation: his mother, who had been pregnant for some months, fell ill again with T.B. and had to be removed to hospital. The father, a labourer of good character but poor intelligence, was unable to look after the two children (Lionel had an elder brother, aged nine), and they were placed in institutions. The Home where Lionel went was not a good one: the children were too subdued and had no toys to play with; the food was not plentiful and affectionate attention completely absent.

After his transfer to this Home Lionel had to stay away from the clinic because he developed skin trouble. When he came back, he showed neither his former enthusiasm, nor antagonism. He began by playing with sand and water as before. He mixed the wet sand carefully, ladled the mixture out on plates, calling it, 'porridge', 'potatoes', or 'pudding'. Much of it was presented to the therapist, the rest was set upon a tray which had to be put on a high shelf, inaccessible to other children, who, Lionel knew, would come to the playroom after him. This variation in play, with its emphasis on the accumulation and preservation of food, seemed to have arisen directly from his feelings of loss when he was separated from his parents and, perhaps, in a more complex way from his earlier feeding deprivations, for his mother had had difficulties in breast feeding. In the infant's mind food and affection are inextricably connected: deprived of affection, Lionel felt himself deprived of food. Giving 'food' to the therapist therefore was prompted by an unconscious desire to propitiate her; he wished to restore to one adult, the therapist, what he longed to take forcibly from another—his mother—that is, her withheld affection.

Lionel's mother remained in hospital for several months. During that time he gradually relinquished play with sand, and transferred his interest to water, to which he sometimes added some paint, and sometimes a few grains of sand. He called these concoctions 'medicine' and pretended to drink

them, usually insisting that the therapist also should do so 'to make her better'.

Young children often attribute illness in parents to their own hostile and antagonistic feelings towards them. This—his need for restitution to his mother, he demonstrated in his play with the therapist. He played at giving 'medicine' to the therapist to reassure himself that he could make her—and his mother—better, that he was no longer a destructive, hateful child, but some one who had the power to 'make' and heal.

Granted that some of Lionel's play might have been stimulated by what he saw around him at the institution—the food and medicines being distributed to children—it still remains extremely significant that he played so persistently with the same materials when a considerable choice of playthings was offered him, and when at the Home he had no opportunity of playing with toys at all. Owing to his early experiences, this material—sand and water—was to him the most significant and symbolic of several important things; hence he used it to express his numerous conflicts, as well as his changing attitudes towards the therapist. The meaning of this later phase of his play had to be communicated to him in different terms: this illustrates how necessary it is to base our understanding of the child's problem not on play interviews alone, but on the whole situation as it is known at the time, that is, the reality situation, as well as the child's imaginative apprehension of it.

MEANING OF BODILY FUNCTIONS FOR YOUNG CHILDREN

Amongst Nursery School children at the toddler stage eating and cooking games are in first favour—what small girl will not sit dolls around a table and spend hours filling dishes with sand which she feeds to her small family?

This absorption in ingestion and excretion has also its symbolic meaning and is especially useful to the therapist in the investigation of disturbances of bowel and bladder, fears of eating, food fads, and the common lavatory fears and phobias which nearly all have their origin in this two to five years phase of life. While many children express these fears through play with primitive materials, others can endow almost any toy with personality and project into it the emotions they repress themselves.

The little boy Johnny described below had suffered from inflammation of the penis following a circumcision operation

six months before he came for treatment. He was a handsome three-year-old—emphatic in talk, with a high-pitched, piping, clear voice, and a manner indicating great strength of will. The problem was refusal of solid foods and fears of using his pot, since his operation. He was slightly constipated but not sufficiently to account for his inordinate fear of defaecation. When he settled down to play he chose several toys, animals, engines, and a toy bathroom set, put each creature in turn on the 'potty', and all passed water but refused the bowel motion. One motor-car on being asked by Johnny would it like to be wound up and make a second try said emphatically 'No, I will not'. Later he played out a day in the life of a child by personifying the skittles as small boys. They consented to go to bed, get up and eat breakfast, but when it came to 'Big Business' all showed excitement and some fear, yet intense interest. Johnny asked them why they objected—one said it was painful, another that he was frightened of falling down the lavatory. Johnny reassured them both and did not realize that at the same time he was ventilating his own fears and asking for reassurance himself. The obstinate motor-car was rebuked, and called 'a bad boy' but towards the end of treatment when Johnny's own fears were vanishing and he could use his 'potty' with success, the naughty motor-cars were petted and loved and told they were only 'little' bad boys. How often does the child correlate 'badness' with inability to control his functions, and how much more difficult the habit is to cure if it is confused in the child's mind with moral issues, as is unfortunately the case in so many children.

SENSITIVENESS AND NEUROSIS

The vulnerability of the gifted, the more sensitive of humanity, is liable to be confused with psycho-neurosis by those whose standards of normality are based on efficiency and productivity. It is through the sense organs, hearing, seeing, touching, that the child apprehends and senses the outer world, and provided he does not close these channels through inhibition, his receptivity grows and he weaves his sense impressions into his experience. If for any reason—fear, shame, or guilt—he attempts to deny their access, he may develop symptoms in relation to that sense organ. A reactive over-sensitivity to noise, for example, may be the result of frightening bombing experiences. This, however, should not be confused with an inborn acuity

of hearing found in those gifted in the field of music or perhaps sensitive to language. An inherent delicacy is not of the same origin as an acquired fastidiousness, the latter caused, perhaps, by a distasteful early experience. This should be remembered in assessing the personality qualities in young children. The innately sensitive are, as children, more subject to vivid dreams, and night fears; from an early age to seven or eight years they commonly experience fears of the dark, which their more lively imagination is liable to people with frightening objects. Being less practical and realistic, they tend to day-dream more, but all these trends are within normal limits, and it should be recognized that although children of this type need more careful nurture in their early years, they are in no sense potential neurotics. This sensitivity in its highest development in the creative mind is well illustrated in the description of the poet Keats in Sheila Birkenhead's 'End of Oblivion':

> Anything beautiful or uncommon would pierce John Keats with a pleasure that was almost pain—it was this hypersensitiveness, this extra-intensity of feeling which made him a poet and which at the same time left him so vulnerable to the emotional blows that were to fall upon him.

Children of impressionable type are often themselves keenly aware at an early age of an intensity of living, of 'being' rather than doing, and we are wise to let them 'discover' themselves through long hours of play and fantasy, uninterrupted by adults. One small boy during treatment expressed this rather neatly by saying, 'Why cannot parents love us for what we are, not just for what we do?' These children react badly to insecurity, separation from parents and loss of affection in their early years. If a child of this more delicate mental structure does suffer from neurosis, being more vulnerable, he reacts more acutely; his mental conflicts are more extensive, have wider ramifications; just because he has keener perceptions and a greater curiosity concerning both facts and fantasy, he falls more readily a victim to repressive measures.

Robin was such a child, impressionable beyond the average. At five, when he was referred for treatment, he was a slim, elfin child, dreamy in his manner, gentle and confiding. His school, where he had been one term, described him as backward, lacking in concentration with much day-dreaming; a poor mixer, but prone to sudden outbursts of affection when he would

impulsively run up to another child and hug it. Roll-call threw him into a state of confusion as he never seemed sure which of his many fantasy names to respond to. He was an only child of a successful, practical father who had been brought up strictly and felt his son should be dealt with in the same way. The mother found her child somewhat of an enigma: she suffered from headaches and could tolerate little noise. Robin's fantasies she hoped to restrain by scolding him and calling them 'fibs'; one of these fantasies was that he had a sister called 'Sooty' with whom he often played and talked in imagination. At home his father had provided him with meccano and other mechanical toys but was disappointed that the boy preferred odd bits of material around which he could weave stories. The parents summed him up as a quaint child with an obstinate, wilful streak in him, but lovable.

Robin's play in treatment was such a combination of fact and fantasy that he seemed to be living in a borderland between the two. All decisions, even the simplest, were put into the hands of others—he declined sand play because the elephant didn't like sand; play with water because the puppies didn't like getting wet. He drew and produced some fantastic animals, 'It's got only one eye, a big mouth, wings, and a long squiggly tail'. He likened the squiggly tail to a siren, which he also drew, illustrating its wail by a long jagged line. He added that there are other nasty things in the night: he called these Wumps—'One of them tries to kill you at night by banging you on the head'. Robin protested that he was not afraid of any of the Wumps but Sooty was—'she is only a girl'. Sooty now takes a foremost place in the play; she is five and a half, she never day-dreams 'because her Daddy said "Stop dreaming this minute" and she stopped'. Sooty, however, likes to play with sand and water; she is noisy and aggressive and seems to express many of the impulses which Robin inhibits in himself. One day he scolded her severely for keeping him late when he and his mother came late for an appointment. Sooty, more forthright, showed her dislike of a Wump by pouring hot water over its head. After a phase of this play, eating and cooking games predominated with dolls in a family group—he had evinced a fondness for dolls a year or two earlier but had been dissuaded from playing with them as unmanly. Robin himself was a small eater needing constant reminders to proceed with every mouthful. Sooty, however, stuffed herself with enormous meals of

sand accompanied by much anxiety on Robin's part that she might burst. One of the rubber dolls was then singled out and came to the forefront in play: he called her Sun Sun and said she was a very little baby. She was a daring small girl and in contrast to Robin, who held his father in awe, she untidied her Daddy's things and lost them: he remarked 'but then she is so young'. One might postulate rebirth fantasies here and the emergence of a new and less father-dominated Robin.

A third figure was woven into his dramatic play in the person of Piggy Wiggy—he is 'a new little boy, but a very dirty boy'; Robin plunges his head into a basin of dirty water to prove it. He is greedy, possessive, and demanding, and shows no shame at exhibiting such qualities. He is altogether more boisterous and rough than the other two fantasy figures. At this stage in treatment Robin began to improve—his appetite enlarged and he took more interest in his meals; he was less detached and dreamy at school and began to speak up in class. In play treatment he now knew when his stories were 'pretending' and would say so—life is beginning to open out, the real world is less exacting and his fantasy world can emerge into reality. Whereas formerly he was happy in neither, now he can accept and enjoy both.

Since the Piggy Wiggy games, Robin no longer spurned sand and played for many interviews at the sand tray 'planting seeds in an allotment'. He became freer in his bodily movements; he dug furiously, using his whole body, arms well into the sand and legs kicking up behind—he explained that he was digging through to another world which is partly the same as ours—'they have our sky and sun but different because that's where Sooty, Sun Sun, and Piggy Wiggy live'—it seems as though he has accepted the qualities they exhibit as his own and is content to let them retire into their own world.

Like many of these imaginative youngsters whose thought imagery is so vivid and insistent, he took several hours to get to sleep—sleep was fortified by bedtime rituals, one of which was that Mother must say 'Good night' three times before he could hope to find sleep—he imagined strange animals and queer objects in the darker corners of his bedroom.

Throughout his whole treatment he played a game called 'eye-shutting': in this he could call up at will any of his fantasies—at first innocuous images like chocolates and sweets, candles and cakes which were Robin's pictures—later the more

frightening objects of his dreams and day-dreams which he attributed to Sooty or Piggy Wiggy. Towards the end of treatment eye-shutting was no longer necessary—he himself said, 'I can look at any of the things now with my eyes open'.

This child with his lively imagination and his ability to people his inner world with fantasy figures found through his life experience, that the only way to satisfy his longings was to retreat into a dream world. This dream world was rich and varied and comes into clear relief in his play. He was released from the domination of his inner compulsion, not by admonitions to be less dreamy and babyish, nor by scoldings at his untruthfulness, but by being allowed to play his fantasies out in a dozen different ways through toys, stories, and his primitive but expressive drawings. The names of his fantasy figures in themselves are significant of their meaning. Therapy not only sanctions for him this dream world which need no longer be secret and hidden but enables him to weave its content into his personality. Affectionate and emotional by temperament, he now learns to turn his warmth of feeling towards school companions instead of fantasy brothers and sisters.

OBJECTS OF TREATMENT

It is believed by some that inner psychic tension is of value in forming character and that to release a child from his fears and conflicts may deprive him of the stamina and endurance he needs in adult life; frustration and denial of childish satisfactions are said to strengthen his personality, hence it is argued that psychotherapy may defeat these ends. This is an erroneous view to take, both of child development and of educative influences.

A child who is kept alone in a dark room or sent to the bottom of the garden by herself to accustom her to the dark as a small girl of six, a patient of one of these writers was forced to do, 'to make her brave and independent', either rebels, or locks up her fears and develops abnormal character traits or neurosis. This type of upbringing, far from building up character weakens and cripples the personality. Suffering is inevitable in the life of human beings, and some individuals are so constituted that they feel pain, whether mental or physical, much more keenly than others. But even in the adult there is a danger that suffering, not consciously accepted, may lead to a form of self-punishment that is called masochism. A small child, being

incapable of this acceptance, is merely puzzled and bewildered by mental pain, especially if he has to bear it alone and in secret, unable to share it with a sympathetic and understanding adult, as so often happens with neurotic children. Psychological conflict in the early years of life is much more likely to lay down the ground plan of obsessional neurosis and depressive conditions, than to help the formation of a socially desirable character. This is most likely to happen with reserved, introverted natures, who tend to submit rather than put up a fight against inner conflicts, as more assertive natures would. This, however, is not an argument against a reasonable degree of discipline being a part of all upbringing.

Treatment aims at discovering the child's own optimum within the limits of his inborn equipment—intellectual and emotional. It is commonly but erroneously thought that treatment has a levelling down tendency, that all the originality, diversity of mental structure and creative capacity which makes for the richness and complexity of human beings is somehow smoothed out in treatment. On the contrary, treatment sets out to liberate the individual, to make him free to express his emotional life and his most complete self, untrammelled by inner conflicts which merely hamper and confine him. This is the aim of all psychotherapy—to discover for the individual his true self and release him from inner frictions which divert his energies from their creative end. A child who has been successfully treated will be livelier, more spontaneous, more friendly, better able to do his work, more enthusiastic about his play and altogether more creative and constructive, but not necessarily more approved of by others, or more docile, as he might have been if standardization, absolute conformity and ironing out of individual differences had been the object of psychotherapy.

Through his treatment and his rapport with the therapist the child learns to accept himself as he is. The therapist is there with his knowledge and understanding, his sympathy and tolerance; he controls and guides the play in directions which he knows will promote recovery. Older children can be helped to gain insight into their difficulties by means of simple words, younger ones by more indirect methods, through the sharing of play, the introduction of imaginary persons as Paul and Robin did, or the play role the therapist is given by the child. In this way they come to realize the impulses previously

repudiated by themselves which can now flow into creative channels. One intelligent boy of nine whose ethical values were beginning to dawn and who harshly castigated himself for injurious aggressive attacks on his young brother when he himself was four, while the more primitive impulses of this age were being explained to him, remarked, 'Oh! I do like psychology —it's taking away that awful "soiled" feeling I've had about myself for a long time; now I can get on with school'.

Throughout treatment the therapist's attitude to the child is not altered by the revelation of the child's 'bad' impulses and wishes: no words of criticism or condemnation are uttered, and the child feels relieved and reassured through the reflection that some one, an adult, knows about his shames and guilts, his fears and inferiorities and is not repelled by them. Neither does the therapist sanction his misdemeanours nor take 'sides' against authority or his parents: this too reassures the child.

In all treatment the therapist has a respect for the human value of the individual child however small and unimportant he may sometimes appear; a child appreciates this and can thrive in its atmosphere. Children are often serious and profound little people, however inconsequent and nonsensical and at times heartless they may seem on the surface. As Hilaire Belloc says of the Wisest Child of All—'He was so small, you could not see His large intent of Courtesy'. An attitude of respect for the child's personality runs through all treatment and calls for that objectivity which consists in keeping the therapist's own prejudices out of treatment and enables the child to see his problems as they are, and not as we fancy them to be. Children differ in their intuition, their insight and their intelligence and each has his own tempo with which the therapist keeps pace. Parents often wonder why treatment takes so long, but, within certain limits, a child cannot be hurried beyond his capacity if enduring therapeutic results are to be achieved. The mind, like the body, takes time to assimilate its nourishment, and reassurance, explanation, and interpretation of play may have to continue for a long period before their final aim—the uncovering and resolution of conflict, and integration and synthesis of personality—is reached. As has been pointed out before, mental readjustment, like convalescence, cannot be hurried: its very slowness may be the measure of its permanence.

CHAPTER VIII

SOME ASPECTS AND PHASES OF THERAPEUTIC PLAY

NATURAL ORDER OF PLAY ACTIVITIES

THERE is an orderly sequence in the young child's development which any untrained mother can observe for herself: certain modes of behaviour appear before certain others in all children. The time of their first appearance may vary greatly in different children; their order never does: fine prehension with the opposition of thumb and finger never precedes the primitive grasp with the whole hand, nor enunciation of words the uttering of various vowel and consonant sounds.

What is true of general development is also true of play, play being, as we have said, only one of many aspects of the child's behaviour. There are phases of play, and phases of predominant interest in certain play materials: in the 'normal' child these phases come and go at their appointed time, provided he has the opportunity of satisfying his play needs. If opportunity has been lacking, a normal child may 'regress' to an earlier stage in his play interests (as Miss Boyce's observation of children at the Raleigh School has shown).[1] With disturbed children, such play regressions are frequent, and have a more specific meaning.

Child psychologists, especially in America, studied development in the first five years of life in such detail that it has become possible to establish norms, with which the individual child's progress can be compared, and his deviations measured. Arnold Gesell,[2] examines development under four broad aspects: (*a*) motor, (*b*) adaptive, (*c*) language and (*d*) personal-social. Play does not belong wholly to any of these categories, for it includes them all; perhaps for that reason no special study of play has been made on a scale comparable to the general studies of Gesell and his collaborators. The attempts to systematize observations on play-development have so far come from individual observers. Of these Dr. Lowenfeld's is, perhaps, the most comprehensive.[3]

[1] E. R. Boyce, op. cit. [2] Arnold Gesell, *The First Five Years of Life.*
[3] Margaret Lowenfeld, *Play in Childhood*, p. 322.

> Play as (1) *bodily activity* is the earliest form of all children's play. During the time that speech is being acquired, play as (2) *realization of experience* gained in previous years is the next necessity of childhood. Play as (3) *demonstration of fantasy* follows hard upon the footsteps of play as interior realization, and interweaves all the way with it; experience feeds fantasy and fantasy feeds experience.
>
> The child of five or six . . . turns naturally outward towards his environment. Play as (4) *realization of environment* is his means of expressing his new orientation.

The present writers have suggested a somewhat similar sequence of play development, using, however, different descriptive terms: (*a*) motor play, various spontaneous undirected movements (*b*) vocal play (producing sounds) (*c*) imitative play (*d*) fantasy play. As has been pointed out earlier, none of these types of play occurs in isolation: motor and vocal play in infancy are usually simultaneous; fantasy play is interpenetrated with imitation. The order given above merely serves to indicate the sequence in which these different types of play appear: motor play is the earliest form, fantasy play the latest to emerge, whether expressive of inner needs or outer experience, and all are conditioned by the child's general development.

As the child's development progresses, his play becomes richer in form and content, and his interest in play materials wider. An infant can appreciate only the simplest toys, hence the folly of giving him expensive beautiful dolls or animals to bang against the rail of his cot or put into his mouth. As his perception develops, he wants to handle everything he sees. His curiosity is all-embracing, but for reasons deeply emotional some materials soon acquire a particular fascination for him. On that account, predilection for certain play materials, as well as predominant interest in certain forms of play, can serve as landmarks of relative maturity. We say about a child: 'He plays like a much younger . . . or like a much older child', and the meaning is clear even though for play development there are no definite criteria.

MISSING PLAY PHASES

A psychologically disturbed child is often one who has lacked opportunity of satisfying his play needs at the time when they were most urgent. His play development did not follow the orderly course, and the result is a mixing-up of phases. As Dr. M. Lowenfeld points out:

> It is the particular feature of neurotic children that they may adopt any form of play at any age, and it is not by any means always the younger child who plays the chronologically youngest type of play. Such anomalies are characteristic of the neurotic temperament throughout life.[1]

Earlier forms of play appear and materials appropriate to an early phase of development are chosen, because the child had missed the emotional pleasure attached to them and has never ceased to feel the unconscious need. A play phase may have been missed completely, or it may have begun only to be cut short. (Something of this kind happened in the earlier phases of the evacuation in this war, when toddlers were rushed in large groups into ill-equipped and understaffed Residential Nurseries.) All of us have experienced the painful and restless feeling of a strong interest being baulked, or an absorbing task interrupted: the Gestalt School has described it aptly as the need to 'close the gap', and experiments have proved that this need is very pressing, for interrupted tasks were the ones that were best remembered, while the ones that were fulfilled were promptly forgotten. The gaping void of unfulfilment clamoured to be filled.

One hears stories of children in the less enlightened orphanages who rush up to the visitors and pass their hands all over their clothes; this could conceivably be due to deprivation of toys and play materials, but it also illustrates the passionate need children have for every kind of sensory experience. To touch, handle, squeeze, or stroke—they must do all that, and if they are given no opportunity at an early age or are directly discouraged from 'touching' things, they might be impelled to satisfy this need at an age when they should be able to make things, not merely to handle them.

In a clinic consulting-room, children are often seen to pick up toys, hold them for a moment, gaze at them, then set them on a table without obvious plan or constructive attempt to play. They take them out and return them to their boxes continually as if the touching, stroking, and looking at the toys were satisfaction enough in itself. We have seen children of six or seven, of normal intelligence, who did this on a number of successive interviews, and never seemed to lose interest as if the handling and inspection of toys alone gave them sufficient pleasure and delight. We might describe such play, or rather

[1] Margaret Lowenfeld, op. cit., p. 323.

inability to play, as 'inhibited'; it is possible that these children dared not give expression to their fantasies, and so had become incapable of imaginative play. But their obvious need to handle and touch has also a therapeutic meaning; it is a play phase they had missed, the gap they must fill before they can proceed further in their play development. This therapeutic need extends from the individual environment into the social and educational sphere, where better opportunities of satisfying sensory experience might be developed through various forms of craftsmanship. To quote D. H. Lawrence, 'We have lost almost entirely the great and intrinsically developed sensual awareness, or sense awareness and sense knowledge of the ancients. Our conscious range is wide but shallow as a piece of paper.' This is a psychological truism which many of our children can teach us anew.

The reliving of missed play phases, described in the case of Lionel in Chapter V, is one of the aspects of the therapy of play. To give the child an opportunity of going back to an earlier phase and to play as he then had wanted to, but for some reason could not, is a case of psychological 'reculer pour mieux sauter'. Unless this is made possible, an unfulfilled, unconscious longing, disguised in a variety of ways, may become an integral part of the child's character, and he may carry it through into adult life in the form of various symptoms, character peculiarities, or obsessional compulsions and rituals. This unfulfilled longing was well illustrated by a small boy aged seven.

Robert was prim and sober and arranged the animals in orderly fields, each group surrounded by a complete fence and no gate—a closed pattern—but when he was asked how he would do it if he were four, he laughed gaily, placed all the animals in topsy-turvy fashion, some on their backs, some on top of fences or straddled across them, motor-cars up trees and men on lamp-posts, and said; 'I like this, it's all nohow'. But the boy of seven he felt he ought to be, despised and was afraid of such chaos.

CATHARTIC FUNCTION OF PLAY

Maurice, a boy of eight years of age, from his first interview at the clinic showed extreme resistance and aggression. He could play only destructively, he tore plasticine and paper to bits, ground clay in the mincing machine, and wanted to leave the playroom before the end of the interview. When persuaded to stay on, he stamped his feet and proceeded to throw the

contents of a large box of bricks across the room. During several subsequent interviews his antagonism and hostility increased until it culminated in his dismembering and then smashing a large dilapidated doll.

After that, his play changed in character, and he initiated a game of pupil and teacher, himself invariably the teacher, the therapist always a 'bad' pupil. She was sent to the far corner of the room and told to sit on a baby chair with an ordinary chair in front of her to serve as desk, while Maurice, as the teacher, barricaded himself behind tables, a bookcase, and stacks of books and toys, at the other end of the room. He wrote on a blackboard and made his pupil copy the lesson accurately. Needless to say, her efforts were always 'wrong' and she had to be punished severely. He addressed her always at the top of his voice, and never allowed her to leave her place or come near the 'teacher's' table unless she was bidden.

This picture may give the reader an impression that Maurice was an unruly, domineering, unmanageable child at school and at home. The reverse, however, was the case: he was timid, retiring, quiet, and submissive. He had been to a clinic when he was three for backwardness in speech, and had had many illnesses in the interval. When he commenced his later treatment with one of us, he was eight, a sickly-looking child with spindly legs, a thin, peaky face and a small mouth which never smiled. His speech was still babyish, and at school, after an attempted transfer to the 'juniors', he was put back in the infants' class.

The family background was far from satisfactory: the parents were on very bad terms—the father bullied the children, especially the eldest son, and was unfaithful to his wife. There were four children, Maurice was the third, followed by a precocious and pretty young sister; a fifth child, a boy, was born towards the end of Maurice's treatment. His head mistress hardly approved of Child Guidance methods and did not conceal her dislike of the boy and disapproval of his family: her only method of dealing with him was to punish and 'shame' him. She regarded his timidity as babyishness and a mere pretence.

Maurice's need to assert himself, to impose his personality on others, to bully and hurt them, as he himself had been bullied and hurt, found vent in the pupil and teacher game in which he was a harsh and punishing teacher, but even here his aggression had an element of defence in it, otherwise why should

he barricade himself as a teacher behind a wall of furniture? As he gave free expression to his feelings, their intensity wore off, their violence was toned down, and slowly this game, too, changed its character.

But play of this kind has limited value in itself—catharsis or abreaction alone liberates the repressed anger, resentment, or destructiveness, but until a synthesis of personality is effected and the child learns how to deal with his unruly emotions, treatment is not complete. It is obvious that in this case much had also to be done to make his environment more tolerant towards him; this, as always, is one of the first steps in treatment.

MEANING OF AGGRESSIVE PLAY

To deal with assertive impulses adequately we must accept them as innate and natural, possessed by all children in greater or less degree. Like all natural impulses in children they must be given opportunity for expression, but this does not mean they should be permitted to run riot. If children in groups or hostels are allowed unlimited expression of aggressive and pugnacious impulses, feelings of guilt are aroused in those who bully, and fear in those bullied, with unhealthy friction and suspicion between the two groups. It is wiser to give the more aggressive children responsibilities and strenuous tasks to canalize their desire for power and mastery. Maternal and protective impulses, domineering though they may be, often then emerge in the more aggressive children towards the more passive.

In treatment, a boy like Maurice, who repressed his aggression in real life because he was afraid of showing it, was able to express it in play, where he was secure with the therapist, who allows freedom yet sets limits. It was as if he were saying to the therapist: 'This is the "bad" me: what can you do to make me like myself better?' This striving for a healthy self-regard is a primary need in every human being, and more basic than the longing for social acceptance, though this is also inherent in his query. The development of self-regard in the child is so much in the hands of his educators: as one neurotically depressed boy put it in clear and unequivocal language, 'When my parents look stern I feel as if they don't love me, then deep down inside me I hate myself'. It is through the friendly relationship with the therapist, with whom such impulses are felt to be less dangerous, that the child learns to come to terms with his frightening and sometimes chaotic, aggressive feelings, and finds what his mind

has been unconsciously seeking, the peace that comes from inner harmony. The same holds true of loving and affectionate impulses, if the child, for any reason, has come to feel ashamed or guilty of possessing them. This is the reason why unmanageable, difficult children at the end of treatment become more affectionate as well as less unruly.

Nor is uncontrolled destructiveness and aggressive behaviour always the mark of an innately self-assertive disposition: a longing for power and mastery is often rooted in weakness with a fear of exposing to the world its accompanying sense of inferiority and feelings of impotence. The need to master life is frequently a fear of yielding to life with confidence.

Billy, described in Chapter V, was not naturally of a robust fighting disposition; his aggressive outbursts, besides being a compensatory attempt to master overpowering fear coming from within, were calculated to protest his 'maleness' and to deny his need of dependence on other people. It is only the mature and truly independent who can accept without self-reproach their human dependence on their fellows. This latter motive also demonstrates itself in Billy's type of play and, when resolved, it leads to a diminution of neurotic aggressiveness. Andrew's play has a similar meaning, but is expressed largely through the medium of fantasy. Andrew was five. He was an excitable, distractible small boy with a keen, eager face, large, expressive eyes and a severe disabling stammer. For several interviews he played 'fierce', shooting games, giggling nervously at his own temerity. He sturdily denied all fear in his personal life—from his history we knew that this was not so. When the therapist mentioned children's fears of the dark, he scorned such foolishness saying, 'Why should I be afraid? I always wear iron armour and sleep with a gun under my pillow. I never need to call *my* mother because it's always loaded.' (The toy gun was his nightly talisman.)

In his play, he was noisy, domineering, and boastful, but constantly 'reining' himself in. He would push all the toys off the table, stage battles with bricks and soldiers and was always on the winning side. Children who have to win in games are often beset by fears of the implications of losing—fears of loss of personal prestige, exposure of weakness, and an incapacity to accept the inevitable failures in life. Andrew produced a wealth of fantasy of his prowess and bravery—he 'once flew over Germany, came down by parachute and met Hitler who was so frightened of me that he hid!' Whenever dreams or his

fears were mentioned his boisterous play got out of hand, a bout of aimless destructiveness ensued and he stammered badly. He asked, 'Did other boys stammer?' and when told 'Yes,' he played a patient and doctor game, advising the other boy to tell his mother when he was frightened at night, and his stammer would go away, something Andrew could not contemplate for himself. His fancied armour is the symbolic expression of his strong and rigid defence against admitting childish fears. After treatment of a few months he 'relinquished' the armour, saying he had thrown it into the dustbin as he did not need it any more. This coincided with the concession of accepting a night-light which he had disdainfully refused before. One day much later in treatment, he came in stammering more acutely than he had ever done before. When words could be distinguished the therapist realized that Andrew was recounting an exciting dream. 'A kicking leg, not a lady's or a man's or a boy's or a girl's—just a leg all by itself—was kicking everything down.' He put the dream into immediate effect and soon there was chaos amongst the playthings. He then drew a person with this most expressive leg and large curves to indicate its sphere of action. This release of intense feeling was followed by a decided improvement in his stammer: the dream and the play had achieved a cathartic function: in his case catharsis could not be effected until after the ventilation of his night fears and the removal of his defences by imaginative play. It is worth noting that the aggression here expressed is partially dissociated from the whole personality—'a leg all by itself' is an irresponsible leg. Much had to be done before Andrew accepted this aggressive organ as part of himself.

The outwardly timid, yielding child is not always the submissive youngster he seems. He is often well endowed with aggressive feeling which is covered up by a polite, controlled social manner, but which emerges undisguised in play. His drawings will be bold and vigorous in style and may be executed with such heavy, forceful strokes that their imprint goes through to the back of the paper. Maurice's drawings were of this type.

Maurice's further play themes were interesting. His impersonation of the punishing teacher having served its purpose, he became an obliging shopkeeper, who sold pretty things to the therapist 'for her children' at a low cost! Later on, as his sense of importance developed, he was Father Christmas showering presents on the therapist, and expecting great delight to be

shown. Finally he initiated a 'mothers and fathers' game in which he played the mother's part, while the therapist had to be the father, and dolls represented their children. His neurotic aggressiveness disappeared not by punitive checking nor by external control, but because it was no longer needed as an assertive or defensive mechanism. His energies could now be directed into school work; coaching in reading was begun at the clinic to reinstate him in school, and his play interviews were gradually reduced. Most gratifying of all, there was no recurrence of nervous symptoms on the birth of the new baby. This event seemed rather to speed Maurice on the way towards maturity. The inarticulate, timid, dejected infant now became a 'big boy', confident and assured.

One may ask whether the more primitive emotions expressed in clinic treatment may carry over into home and school life. To some extent they do, and parents are asked to be more tolerant of swaying moods and noisy outbursts until further integration takes place, and the child's unruly emotions become canalized into various forms of positive achievement. When parents see that at the same time the child becomes less fearful, sleeps better, and perhaps stammers less, or wets his bed only infrequently, if these have been outstanding symptoms, a tolerant attitude comes more easily. But still another factor operates in the situation. Even the youngest child is aware of the subtle difference in atmosphere between the therapist's playroom and the outside world, and intuitively responds to this knowledge, realizing that certain extremes of mood and behaviour and personal expression are for his therapist only, and not for any one else. This is often clearly demonstrated by the type of drawing a child does, awaiting his interview, and those he uses to illustrate his play themes in treatment; one small girl of six, whose therapeutic progress could be read into a series of drawings of terrifying tigers in family groups, always drew the most innocent houses and fairies in the waiting-room.

TYPES OF PLAY IN DIFFERENT VARIETIES OF NEUROSIS

It is possible to generalize and divide children who come for treatment into two groups:

1. Those who have suffered some shock, or fright, real or imaginary, the emotional repercussions of which have been repressed into the unconscious and to a greater or less extent forgotten.

II. Those in whom there is a slow-growing but subtle personality change extending over years. This group will be discussed in greater detail later.

Group I. Incidents in a child's life which are traumatic in nature sooner or later emerge in his play.

Michael had suffered from the shock of falling into the fire at the age of three. Not long afterwards he developed a habit of flapping his hands which persisted until his teacher wisely decided, when he entered the Infants' Class, to have his symptom investigated. His mother was of the kind who makes stock of her children's ailments and had recounted his accident to the neighbours in his presence. In his play Michael relived this incident, which some time later he verbalized in the following way: 'I have to wiggle my hands because mother says the shock was so bad that it came out of my fingers and it has been coming out ever since—if it didn't, she says I would go daft!' His fears of insanity, not altogether uncommon in children, had to be kept at bay by a compulsive habit which brought its own measure of adverse criticism both at home and at school.

The emergencies of war-time and experiments in evacuation have brought sharply into relief the psychological effects of separation of young children from their parents with the loss of the familiarity and sense of 'belongingness' of home.[1] One must review also the psychological effects of hospitalization in over-anxious young children, especially in those cases where parents are not allowed to visit them except at long intervals. The well-adjusted child, free from conflict, accepts short separations from his parents, including a stay in hospital, without emotional upset, but a child, of whom there are many in war-time, who has already suffered from an unsettled life and many separations from home, reacts badly, and to him hospital experiences represent a traumatic incident. Much could be done to obviate such effects if nurses were more aware of the child's psychological needs and if parental visiting were permitted, even at the expense of stormy crying for an hour or two on visiting day. Stormy crying releases feeling and has therapeutic value—it is much healthier than a resigned acceptance of deprivation, with the danger of emotional withdrawal.

Teddy exemplifies some of these points. He was a little boy

[1] John Bowlby, 'The Influence of Early Environment in the Development of Neurosis and Neurotic Character', International Journal of Psycho-Analysis, April 1940.

who had suffered all his life from the stresses of war; he came into the world the day Hitler entered Warsaw and has been on the psychological battlefield ever since. He had lived in town and in the country; with his mother, with an aunt, and with strangers. His life was not made any easier by the inconsistent handling of an anxious mother. He was brought for treatment as difficult to manage, with constant crying: his response to every friendly gesture at home and at Nursery School was a tearful but angry, 'No.' These symptoms had been exacerbated by a recent severe illness in hospital. He was a solid, husky boy, but clung to his mother, giving the therapist hostile, furtive glances. His attention, however, was soon captured by the sight of the toys and he found himself divided between a growing interest and a fear of being left alone with a stranger away from his mother. He soon launched into an absorbing and more or less incoherent story of a horse which was knocked down in the street and run over; 'and it cried so much it was put to bed and given hot drinks by its mother'—this was illustrated with the animals in the sand tray. Further elaborations of the same theme ensued—dolls were run over and taken to hospital by ambulances —and how they cried! It was interesting and revealing to listen to the small boy's reassuring tones as he, the doctor, ministered to the 'injured' babies, telling them not to cry as their mothers were not dead and would come back to them. Young children equate death with separation and absence from their loved ones.[1] They cannot yet appreciate death abstractly, but their play of 'deading' people clearly demonstrates that death has both an aggressive, punishing component, and an anxiety element, that is, the fear of loss of the person 'deaded'. How much more they will fear this loss if added to the separation there is bodily pain, a threat to life, and the bewilderment of acute illness! Hospital treatment is not of course always avoidable, but some of its accompaniments: the psychological effects of loneliness, fears of the dark, and prolonged absence of the parents might perhaps be obviated.[2]

Disorders due to some specific incident or series of traumata are likely to clear up with play treatment, in which the reliving of the disturbing experiences, with little or no interpretation, is sufficient to effect recovery. Many of the anxiety states and some of the hysterical reactions fit into this category: the more recent the shock the more readily does it yield to treatment.

[1] Sylvia Anthony, *The Child's Discovery of Death.* [2] Edelston, op. cit.

Teddy projected his fears into the horses and dolls who suffered as he had done; he played ambulance games, 'falling down in the street' and 'deading' games until he familiarized himself with what he had feared so much, and gradually his fears disappeared and were replaced by confidence. A trauma, however, is never isolated in the mind; it becomes inextricably mingled with the emotional life, producing symptoms far removed from the original central theme. Separation and threats to his security had been the background to Teddy's whole life; the hospital with all its concomitants had served as the precipitating cause, bringing all his repressed fears to the surface. But let it not be thought that treatment is as simple as the above account might suggest; the therapist must keep in mind all the ramifications of the conscious and unconscious conflicts with which training has familiarized him, and these as well as the central theme are brought into the play.

Group II. The second group is that in which neurosis has developed more insidiously and perhaps to the surprise of the parents. Outwardly, the home appears satisfactory. The children are well cared for materially. There have been no major upsets nor developmental set-backs, no outstanding traumatic incidents or illnesses: nothing to break the outer routine of home life. There is a sufficiency of toys and facilities for play. What then is the cause of the psychological illness?

Some children are brought up in atmospheres which are inimical to healthy child development. Standards of conduct and behaviour are founded on a false basis of external appearances and utilitarianism, neglecting the child's deeper, more fundamental needs. There is the closed family group that fears and avoids the influence of other children or young people; the family whose mental climate is so stoical and unbending, that childish pain, discomfort, and fears must never be mentioned. Some children are overshadowed by reason and logic too early. Father Christmas, fairy stories and the rest of the world of fantasy and nonsense are excluded from their lives and the emotional life is dwarfed. Then there is the peculiarly insidious atmosphere where few protests are uttered by the parents, but displeasure fills the house at every evidence of youthful emancipation. 'Mother isn't cross but only deeply hurt.' Sadistic and masochistic reactions flourish here.

There are the parents who bring up a whole family with a supreme disregard for uniqueness of individuality and insist on

all of them fitting into the same mould. There are the over-critical parents, too scholastically ambitious for their children, insisting upon school successes to the exclusion of play needs. There are the more obvious examples of the harsh, overbearing father, whose demands for silence inhibit free thinking in his offspring, or the obsessional mother whose gods are order, punctuality, and cleanliness and whose adherence is to the letter, rather than the spirit, forgetting that 'the spirit quickeneth and the letter killeth'. Whether these influences are conscious or unconscious on the part of the parents they affect the child adversely.

The danger to healthy psychological development here is that the young child unconsciously absorbs such standards and patterns, and early comes to believe them to be his own. He develops a tyrannical, unyielding superego and a habitual attitude of condemnatory criticism of his more natural self. Two personalities begin to emerge, the one in conformity with his environment, the other his own, but always uneasy, inhibited and guilty. Out of this soil grow the obsessional neuroses, the withdrawn shut-in characters, the apathetic and depressed, the inhibited and the masochistic; all those whose personalities have suffered a slow and subtle change, but whose symptoms impinge so little on their environment that they are much less likely to be brought for treatment than are the over-fearful, the rebellious, and the aggressive.

OBSESSIONAL PATTERNS

The play of the obsessional child in the first few interviews was mentioned in Chapter V. Obsessional neurosis in the adult is a condition requiring long and intensive analytic treatment and even then it does not always respond to therapy. We are becoming increasingly aware of the danger signals in early childhood pointing to the incipient stages of this illness, and are realizing more and more the importance of detecting and treating this neurosis in small children before reactive changes have occurred in the personality. Amongst the danger signals are the compulsions and rituals of action and phraseology. One unhappy little girl of five with a phobic fear of water and the sea, always came to treatment clutching a baby's bottle from which she would not be parted. Whenever she felt frightened she sucked the bottle, and that 'kept the sea out'—the bottle had acquired ritualistic value. Scruples, fears of inaccuracies and inexactitudes

are common, but most outstanding are the subtle changes of the whole emotional structure resulting in the reactive personality, which develops as a superstructure to the real personality, successfully concealing it not only from others, but from the child himself.

There are some childhood rituals which can be accepted as comparatively normal especially if they are isolated phenomena. If Robin's 'Good night' ritual had been his only symptom it might have been disregarded. A boy of eight, who must touch every second paling of a fence as he walks down the street, is not necessarily an obsessional neurotic, but when a child must make a pax sign with his fingers incessantly, or is impelled to turn to the left and say 'No' aloud to certain thoughts invading his mind, then investigation does seem called for.

The obsessional pattern is often well defined at the age of six or seven, although it is never so rigid nor so closely knit in children as in the adult, and a certain measure of anxiety does come through to consciousness. For these reasons and also because obsessional conditions have a high incidence in civilized societies, it is thought worth while to describe the mechanisms underlying its psychopathology in some detail.

During play treatment this reactive personality can be studied. In the early stages of treatment its influence determines both the type and content of the play. It is this personality which scorns untidy paintings and carefree fantasy, and decides that a dolls' house and the sand tray are only for 'babies'.

The outstanding mechanisms in the obsessional character are first the denial of feeling—children even of four or five will deny that they are ever afraid. Andrew who refuses to divulge his dreams and wears 'armour' is obedient to this inner demand. They scorn affectionate approaches and are deluded into thinking they need no cuddling or fondling; they become stubborn and silent in face of opposition rather than exhibit anger or rebellion. This denial of feeling results in a withdrawal into themselves and a characteristic sense of isolation and secretiveness which puzzles parents and builds up barriers between the child and other people. Secondly, not only is the primitive urge, for example, the anger, repressed, but there is a tendency towards the development of the polar opposite of the emotion experienced. Aggression becomes converted into anxious solicitude; the little girl, who at three had temper tantrums, is now at six a 'real little mother', but such an anxious mother, to her baby sister.

Earlier tendencies to show off and exhibit herself are now replaced by bashfulness, prudery, and excessive shyness regarding her body. Curiosity and normal inquisitiveness are repressed, and the child comes to believe herself indifferent to any excursions into imaginative thinking. Grubbiness and delight in dirt and messing are overlaid by a compulsive need to be clean, neat, and excessively orderly. (These are the children mentioned in Chapter V who reject sand as 'dirty stuff' or who cannot paint because it soils their hands.) A small boy of five, one of our patients, sat 'reading' the National Geographical Magazine each week, in preference to playing with toys, for two months at the beginning of his treatment.

The third mark of the obsessional neurosis is the particularly harsh and unbending superego with the ever-present sense of guilt. This has no relation to the conscious, normal guilt a boy might and should feel if, for example, he has been stealing, but is rather the niggling guilt of the scrupulous and the apprehensively over-conscientious. It is this guilt—the 'contaminated' feeling of wrong-doing that has no factual basis that motivates the ritualistic behaviour and compulsions which then have magic value for the patient. Guilt is often symbolized by dirt which is one of the reasons for the refusal of dirty play in certain neurotic children; a similar mechanism operates in the phobias and delusions of disease and infection in adult neuroses and psychoses, disease symbolically representing the unconscious sense of guilt frequently accompanied by expiatory hand-washing rituals. There is enough of the primitive in most of us to make us touch wood to avert certain catastrophic disasters, but what would we say of a patient who must spend two or three hours in preparing for bed each night in obedience to an elaborate bedtime ritual? Such behaviour is compulsive and serves both to master unconscious fears of certain primitive drives, and to expiate for being the possessor of such impulses and wishes. A young boy with touching rituals expressed this in the following way: 'If I touch a person accidentally with one hand, I have to touch him with the other "to make it fair and equal", but I only need to do it when some one is sad or angry—especially if it's Mummy—I feel then as if it's my fault and I have to touch things to undo it.'

OBSESSIONAL PLAY

There are certain outstanding characteristics of play in children where the reactive personality is developing—the correct over-'good' child can never get down to play, so busy is she in preparing and cleaning up. She offers to wash the sink and take home the towels to launder. The sophisticated and precocious child, mature beyond his years, scorns dolls, animals, or anything that may betray affection or other emotions; he chooses jig-saw puzzles, or offers to bring Meccano which he knows would keep him clear of fantasy. Withdrawn and over-independent children play with mechanical toys and tend to keep animals and people out of the picture. An obsessional boy conceived a mechanical plan of the human body and worked it out in terms of pulleys, cranes, and levers: 'then there would be no diseases, no tempers and everything would be sure'.

The therapist reads into the play the meaning which is hidden by the child's carefully guarded exterior, his polite manner, his superficial poise, precise speech, and patterned behaviour. His play alters, of course, as treatment progresses and he sheds the defences, now no longer necessary to him.

Certain children demonstrate particular aspects of the obsessional picture. Andrew, in Chapter VI, denies fear and his need for affection, and attempts to graft a grown-up mind on to a child's psyche.

Pamela, described in Chapter V, is a child who illustrates many obsessional mechanisms. She had a gift for language and was highly imaginative so that these mechanisms could be clearly demonstrated in her play. Her lively fantasy life had unfortunately been disapproved of by her father. Amongst her symptoms was constipation of a neurotic type, masturbation, and many phobic fears, one of them a terror of the noise of the lavatory chain. Therapy revealed a consuming but repressed curiosity regarding bodily anatomy and functions. There were frequent dreams of 'horrid big animals' and night terrors.

In her treatment she played for several interviews with a bathroom set, putting the baby on a pot, treating him with suppositories and syrup of figs to secure the desired result. The baby was negativistic and would respond only into a napkin which 'the mother' cleaned up very crossly. Pamela disliked sand and plasticine which she called 'dirty'. This play with the baby was a fairly accurate reproduction of her mother's handling

of her constipation and early gastro-intestinal upsets. One must never, however, assume that all 'family' play mirrors the child's own home.

Then 'a naughty man from a far country' appears in the play; he wore rags, washed them in the lavatory and had no qualms whatever about getting himself dirty. Here the child is commenting not only on outer events and her mother's management of her, but is protesting against the demands of her own inner prohibitions.

Pamela now spent a few interviews playing with the dolls' house and a doll; a mother doll was put to bed because she had a baby inside her. Pamela volunteered that she too was growing a baby: (she had been told by her mother of the facts of pregnancy but not of birth.) In a later interview, while sharpening some pencils, Pamela called the sharpener a lavatory and the shavings faeces. She then 'married' two pencils and did a highly descriptive drawing of two pencils sitting on a double lavatory and a baby one going down the lavatory. It was obvious here that she correlated birth with excretion as many young children do and was asking both for information, and for sanction for such curiosity, especially when she added that she herself always used the lavatory for urine and a chamber for faeces, and inquired, 'Is that because a baby might come out of me?' This type of play ceased when she knew that only grown-ups have babies; at the same time her constipation cleared.

She was an emotional child with a rich feeling life and, as mentioned before, was subject to attacks of shivering which she called her 'excitements!' The parents were under the impression that this should be restrained, and the child herself said she took calcium 'because mother didn't like excitements and calcium stopped them'. 'The nasty excitement', she said, 'I call the "Beastly Beast" and he is not always the same: sometimes he is black and white with untidy hair, messy clothes, and rows and rows of teeth and no arms.' (He is both aggressive and messy but is deprived of some of his potential aggression by being armless.) 'The other is blue and gold, is nice and kind, has a small mouth and only two rows of teeth, but he hates soft skin so much that he pinches it.' (This latter remark also demonstrates her ambivalence and her acceptance of opposing qualities in herself as treatment progresses, for neither of these figures is wholly good or wholly bad.)

A third type of play was connected with earlier illnesses and

centred around eyes and spectacles. The pieces of bathroom furniture in this series were given names, and, as small boys and girls, they visited the eye-tester who found that they all needed dark glasses; only one—the wash-basin—refused his, and he created a great stir by throwing them off; he was punished by falling ill with pneumonia. The child then drew a girl in bed, wearing spectacles 'because her eyes are very weak and dim—she is ill, her eyes are crooked and she can only talk dimly'. Pamela remembered having measles at the age of three, when like other children she suffered from painful eye symptoms, and recalls that her eyes were weak and she thought she might be going blind.

It is interesting that this memory came during the phase of play relating to the bathroom set, that her phobias centred around the bathroom at home and that her parents were prudish with regard to bodily anatomy, and had given her no names to designate her organs or make known her wants. She commented one day—'My mother calls the part you sit on nothing—what do you call it?' There is a close connexion between the taboo on seeing, looking and peering, and the use of the eyes: many children repress not only looking at the forbidden object but all the imagery which has any connexion with it, with a reduction of the whole of imaginative thinking, and the development —in some cases—of conversion symptoms, such as squint, difficulty in convergence, headaches, and eye tics.

Like Robin, Pamela has a lively imagination; he deals with his conflicts by retreating into fantasy, Pamela by the development of an obsessional personality—too tidy, too clean and orderly, with a false maturity beyond her years, and shame at accepting her more childlike self. One day she asked, 'How do little babies that can't walk tell their mothers when they are frightened?' Robin deals with his problems mainly through dramatic play, Pamela through a combination of fantasy play, and play with toys, from which she selects a bathroom set, plasticine, and a few dolls which she unconsciously knows will most satisfactorily and completely express her conflicts.

THE CHILD'S ATTITUDE TO TOYS

The child's particular apprehension of the world is different from that of adults. Although in his play he is absorbed with objects—his toys and materials—he sees them not as isolated entities realistically, but in their symbolic sense and in their

sense of relatedness to other objects and to a whole. Skittles can be small boys, a pencil sharpener can be a lavatory, wash-basins can wear glasses and see as children do, while the therapist can be herself, a mother, or the audience at a pantomime. The child 'lives' through his toys, he feels through them, he uses them in their variety of meanings. This is why he can express such a complexity of experience through the simplest of toys, and why—provided the essentials are there: water, sand, animals and 'people'—he is better without too complicated, intricate, or formalized play material which diverts his interest on to the material rather than into his own emotional experience through it. The same object, a battered doll, for example, may be a baby one day, a mother the next, a scarecrow keeping enemies away the next, or a witch against whom other characters in the play have to be defended. In each case the choice depends on the imaginative content of the conflict with which the child is dealing in his play.

Pamela's conflicts have many ramifications and invade almost her whole feeling life including her curiosity regarding birth, and the fantasy wish and fear of having a baby herself. Children with inquiring minds and a rich imagination are in need of knowledge of the 'facts of life' earlier than the average child, and should be answered by their mothers, as their questions arise, if morbid curiosity is to be avoided. It is often these children, richly endowed emotionally, who, frustrated of creative outlets, turn in on themselves with masturbatory habits, accompanied by a sense of loneliness, isolation, and unhappiness. All Pamela's symptoms, her constipation, masturbation, her phobias and the fantasy fears in relation to her eyes, are linked together, and the punishment she metes out to the rebellious bathroom figure who refuses to wear glasses, represents her own guilt for forbidden looking. Her repressive mechanism centres around her keen interest in the body, its parts and their functions, and what the body can do and make. All of this she externalizes through an intricate play pattern, chosen and initiated by herself, but made comprehensible and acceptable by the therapist.

The superego, or moral standards of little children tends to be over-severe towards small transgressions. Psychological investigations, such as Piaget's[1] have shown this independently and parellel to the findings of psycho-analysis. The younger the

[1] Jean Piaget, *The Moral Judgment in the Child.*

child, the sterner his judgment on the transgressions of his equals, and the severer the punishment he deems suited to his own offences. Pamela's teacher-pupil game illustrates the harsh superego: few teachers are as tyrannical as her play depicts them. Similarly, cruel dominating parents are often an imaginative reconstruction of superego demands and not at all a true picture of the child's home life. Young children in this respect are similar to barbarians at the dawn of civilization: humane ideals and practice are the fruit of maturer minds and higher civilizations, and allow of reasonable human failures and mistakes. The mentality of retribution and ruthlessness is symptomatic of emotional immaturity. A healthy conscience discriminates between transgressions that are major or minor, voluntary or involuntary, malicious or thoughtless, and judges accordingly. In treatment it is the therapist's unfailing friendliness, tolerance, and respect for the child's personality which help him to modify his retributive superego, and allow him gradually to become tolerant and yielding, rather than exacting and tyrannical.

OBSESSIONAL INTEREST IN BIRTH AND SEX

Fanny was another little girl with obsessional tendencies. Thinking of a ruminative and compulsive type was prominent in her story. Fanny was eight. Her symptoms were bad dreams, bouts of bad temper and petulance every five or six weeks, various phobias and fears of traffic and crossing the road, the latter especially when her mother and small sister were with her, when she insisted on walking on the kerb. Her mother was thin and overactive, with a taut expression. She had married at thirty and did not want children. Her own home life had been unhappy; the father a habitual drunkard, had ill-treated his wife and deserted the family when the daughter was fourteen; she was kept in ignorance of sex knowledge which came as a rude shock on marriage. When she did become pregnant, she was overcome by fear and dread and had to walk up and down to calm herself. Breast feeding was impossible, and whenever she carried the child, she was obsessed by fears of letting it drop. The baby was brought up by the clock and developed screaming fits which continued till she was two. When she was four, a second child, a sister, was born; the patient showed signs of jealousy, pinched and slapped the baby, for which she was punished. The mother's methods of upbringing vacillated

between over-protection with fussing over illnesses and chills, and an impatient, resentful attitude towards children. The father was kindly, more understanding with children, but inclined to keep in the background. With the war came fear of sirens, and Fanny was sent off to a Nursery School at the age of five. A change came over her then; she was described as quiet, 'too restrained and good' and too solitary; periodic but less frequent screaming attacks still occurred. On returning home at the end of a year she developed many fears of an obsessional type; for example, she would not touch a spoon or cup which had been handled by others, she became fastidious over food and developed fears of disease and death. She was prudish about her body and locked the bathroom door while bathing: certain rituals appeared.

Fanny was a round-faced, well-built girl—solemn, shy, and aloof. Stiff and prim, she sat on the edge of her chair in the early stages of treatment, her voice muted, her talk guarded and suspicious. She began treatment with some drawings. These were neat, careful 'patterns' but gay with colour. The next few interviews were spent playing a game of being a little girl, going back to babyhood, then up to eight and back to infancy again. 'I'd like to do that for ever and never grow up.' One day later in her play with dolls she remarked shyly: 'They don't have grown-up dolls, I wish they did. I often wonder why ladies grow out and daddies don't.' Her mother was advised to give her some simple information about pregnancy and birth. It then appeared that in a roundabout way Fanny had put questions to her embarrassed mother, who complained: 'She's a strange child, she asks such lewd questions about her body, the nipples and the navel—I don't know how to answer them; she's such a complicated child you never know what she's thinking.'

Parents so often fail to appreciate how realistic children's thinking is. A small boy asking gravely whether a mother's nest is lined with straw like a bird's, is not lewd but logical. Parents are frequently shocked at questions such as how a baby gets his food and keeps warm during gestation. In the child this is not so much an interest in sex as in practical issues. To young children the facts of pregnancy and birth are just as fascinating as any other true story, and it is only the adult orientation, placing too much accent on their sexual connotation, which makes them seem 'rude' or salacious. Parents could

more easily satisfy their children's questions on this subject if they could see them as part of a child's general curiosity and not specifically sexual.

It is also true that the younger the child the less likely he is to be disturbed by the simple statement of facts of pregnancy and birth, for his thinking is still too concrete and matter-of-fact to allow of imaginative elaboration, more common at a later age. He may even quite soon forget the facts he has been given and spin out some childish theory of his own, or he may relinquish his newly found knowledge in favour of his earlier fantasies and theories, like the little boy of six who knew that babies grew inside their mothers, yet when his own mother became pregnant reverted to his earlier belief that they were brought from the hospital. Mothers are often puzzled by this capacity of children, attributing it sometimes to stubbornness or to lack of interest, or even to a desire to put mother in the wrong. But they can be reassured that the children have absorbed some part of their information, and more will be digested later as the child's intellectual and emotional understanding become welded together.

What the child does gain from such enlightenment is the feeling that his parents do not hide from him something in which he is vitally interested, that they try to be truthful with him, and that his questionings are natural and 'all right'. This frankness gives him confidence in them and, as a consequence, in himself. The danger of their evading or telling him untruths about the origins of life lies in this—that once the young child discovers that his parents are dishonest with him, his trust in them is permanently undermined, and an irreparable injury has been done to a relationship which is a basis and a pattern for most future relationships between the child and others.

Fanny's mother was given some help and advice on how to deal with these questions, and she did so. A few days later in treatment the child was playing in the sand with a father, a mother, and a baby pig in a trough when a thought crossed her mind. She asked how long it would be before she could have a baby. When told she remarked sadly, 'It's an awfully long time to wait until then'. Later interviews produced a spate of questions, some of them on the subject of 'babies' and others of a different type. She asked what old people die of, what babies die of, why people do die, and can they come alive again: did mothers die having babies; did Adam's mother die when she

'got' him, and who was Adam's Mummy? One does not attempt to answer accurately all of a child's obsessional questionings (even if one could)—it is more productive to discover where the questions are leading. Here it is obvious she was concerned about birth and death; her interest in birth repressed because of her mother's attitude; her preoccupation with death complicated both by her fears of losing her family through air raids, while they were in London and she was in the country, and by her aggressive, jealous wishes against her young sister. After a few more interviews, Fanny sat down and painted first a baby in a cot, then a long green dress, the dress she intended to wear at her wedding. She became more friendly and natural; an attractive, intelligent, reflective girl began to emerge: a girl who showed herself as warm-hearted, sensitive to atmosphere, evincing a keen sense of inquiry about every aspect of life.

Children of thoughtful type ask many abstract questions about life. Fanny asked, for example, 'How far is it to the sky?' and 'Where is the edge of the earth if it is not round?' but in obsessional children these general questions often serve as a screen for more emotionally charged and personal queries repressed through anxiety or guilt.

This is only one aspect of Fanny's treatment. She must have early sensed her mother's inability to accept her own femininity and her role of wife and mother. She adopted her mother's standards as her own, and attempted to stifle her deep longings to question and ponder, and delve into her imagination and her own feeling life. Children who develop the obsessional character are often intelligent, intuitive, and astute. They are sensitive to atmosphere, avid for knowledge, and when they find their curiosity about life disapproved of, they unconsciously conceal their enthusiasms and inhibit any further desire to know. This explains the secretiveness, the inner, concealed life of the obsessional, the disguised emotions and the reactive trends. It also explains the unconscious guilt and its correlation with dirt, disorder, and carelessness which the child tries to exclude from play. Treatment demonstrates that for the child knowledge is never enough. Fanny asked the same type of question again and again, but she was not free of symptoms until that knowledge was assimilated and she made it her own. To know is not enough, the child must feel and 'be' part of that knowledge before integration takes place and wholeness is achieved. When Fanny's obsessional questionings were satisfied, her fears

of disease and death vanished: both her over-solicitude for her mother and sister and her periodic tempers disappeared. She lost her sense of isolation and became more communicative and friendly. She began to look forward to growing up and at the same time allowed herself to be a lively small girl.

In considering Fanny's story one is reminded of Jung's little patient Anna whose small brother was born when she was four.[1] Anna showed some symptoms of unrest and anxiety, but to her parents' surprise developed a keen interest in geology, asking innumerable questions about volcanoes and earthquakes and their causation. She was a highly intelligent girl, and less wise parents might have precociously stimulated mental development by encouraging such an intellectual interest. They realized, however, that childish curiosity, if tinged with guilt, may not only be inhibited but transferred into another sphere, often an intellectual one. This they proved by answering her unspoken queries about the origin of the baby brother, when Anna's interest in geology subsided.

The outstanding point that needs to be stressed is that it is *natural* for a young child to be interested in his origin, and that the parents are the right people he should question about it. Yet, parents of children of eight and nine frequently reply to the social worker's or the therapist's question: 'Oh, no, he has never asked us questions about babies or about sex'; as if because he has never talked of it, he has never thought of it. Unless the child is of subnormal intelligence or entirely lacking in imagination and wonder, this may mean one of several things. The child may have been already 'enlightened' by other children, who, with scraps of distorted information, have also communicated to him the feelings of secretiveness and shame which goes with forbidden knowledge. He has not asked his parents questions because he was ashamed or afraid to do so. He may, of course, have asked them indirectly at some earlier date, and his parents had put him off on the grounds that he was 'too young to be told', but in fact because their own feelings of embarrassment would not allow them to treat the subject with simplicity and frankness appropriate to the child's age. The parents themselves may have 'forgotten' his earlier questioning in the way in which many embarrassing experiences are 'forgotten'. Or he may never have attempted to ask them, and refrained from seeking knowledge elsewhere because he has intuitively grasped through their attitude to the subject that

[1] C. G. Jung, op. cit.

it was somehow shameful, 'dirty', and to be avoided at all costs. By this his curiosity may have been repressed, but not disposed of, merely left to operate below the level of consciousness, and probably in conflict with shame and fear. There is little doubt that many neurotic symptoms, including the over-intellectualization of the obsessional, as shown in Anna's case, as well as behaviour disorders, such as delinquency,[1] originate in conflicts of this kind.

SIGNIFICANCE OF THE CHILD'S QUESTIONS

The obsessional longing to know all, to be rid of doubts, indecision, and uncertainty has its roots in insecurity. Children whose emotional background is secure and trustworthy are less liable to ask innumerable questions and are more content to accept the unknown and the unanswerable in life. The neurotic mind craves for completeness, finality, and certainty as a defence and a talisman against the unknown, which appears to it as a threat and a danger. The perfectionist mould of mind, part of the obsessional reactive personality, repudiates indecision, doubt, weakness, mistakes, and even in the young child builds strong defences against their expression and their acceptance. Play, however, reveals what is hidden by the outer mask of personality, and it is through the therapy of play that final recovery may be achieved. Therapy tries to convey to the obsessional patient what is so succinctly expressed in a few lines by the Irish writer James Stephens: 'Finality is death. Perfection is finality. Nothing is perfect. There are lumps in it, said the Philosopher.'

Obsessional conditions, like the other personality deviations mentioned earlier, require long and intensive treatment; much more symbolism enters into the play than in neuroses due to traumatic incidents, and the play themes are neither so clear-cut nor so realistic. The conflicts which are buried more deeply in the unconscious must be approached from several different angles, and are usually played out by the child spontaneously through a variety of different media. Only experience can teach the therapist which play materials and which methods of approach are of greatest value for the individual child; only experience can guide him towards the understanding of the symbolic value of play; only through much study of his art will he know whether the play at any moment is expressive of

[1] William Healy, *Mental Conflicts and Misconduct.*

abreaction, of a defence against, or of a release of, conflicting emotions; whether it is wise to make interpretation, and if so when and how.

Through play the lively fantasy of child life is expressed and turned to constructive, therapeutic ends—through play with primitive, simple materials and toys by means of which the child can depict his imaginary and real life.

By making use of play in psychological treatment a double task is fulfilled. The child is set free from his neurosis, his fears and his conflicts, and with the aid of the therapist recovers his wholeness. At the same time the therapist discovers a new way of access to the child's mind, and by his studies extends the knowledge of the structure and dynamics of the child's rich and complex mental life. The spontaneous play of young children has suggested to us a new method of therapy, while therapy through play has proved to us afresh how necessary for the emotional development of every child is his fantasy and play life; how immensely important at certain stages of his existence it is in enlarging his awareness of the inner and outer world, and in educating the feeling and intuitive aspects of his mind.

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